The American Journal of
NURSING

Volume XXX AUGUST, 1930 Number 8

Radium, Radon, Radiumtherapy

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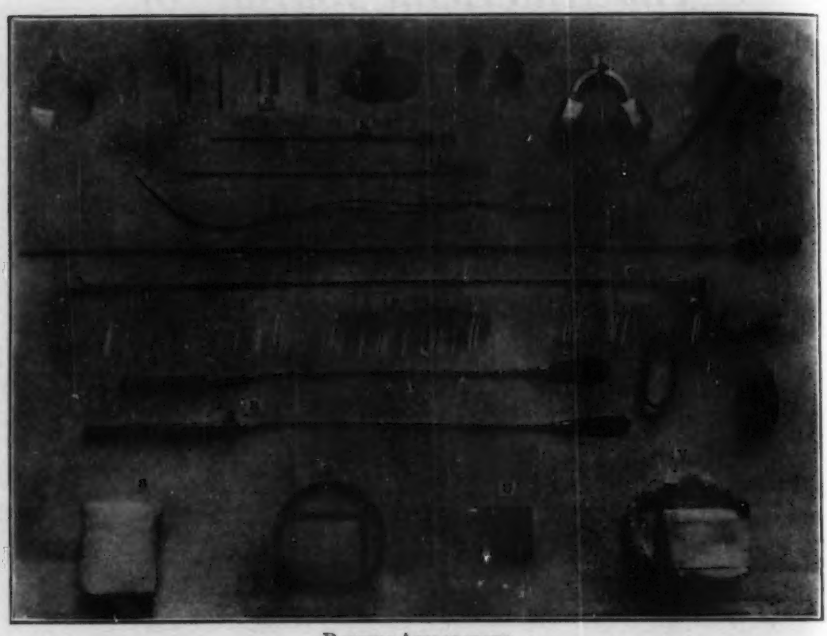
RADIUM is the chief member of the uranium series of radioactive elements belonging to the alkaline earth group of elements. Its parent is ionium and its disintegration product is radium emanation or radon. Radium occurs in nature in the salts, radium sulphate, radium chloride and radium bromide which are in combination with uranium compounds in the form of pitchblende and carnotite. The radium salts of commerce are white or greyish powders which glow more or less brightly in the dark. Minute amounts can be found in all soils, rocks, oceans, springs, etc. However, there are places where the element is found in comparatively large quantities. The largest deposits are found in the Belgian Congo. The radium supply in this country has been produced from carnotite ore found most plentifully in Colorado and Utah. To obtain one gram of radium it is necessary to treat 500 tons of carefully selected high grade ore, and in the task nearly 1,000 tons of chemicals must be used. The process is a costly one. The present price of radium is $70,000 per gram.

Soon after Roentgen discovered x-rays in 1895, Becquerel of Paris found that certain uranium salts produced rays similar to them. About two years later M. and Mme. Curie succeeded in extracting from pitchblende two new elements, polonium and radium. In 1899, Danlos commenced studying the effects of radium rays on certain skin lesions; and in 1906, Henri Dominici set forth the principle of ultra-penetrating radiation.

It is generally the duty of the nurse to make up all applicators used in radium therapy, therefore she should familiarize herself with the physics of radium. To obtain a clear comprehension of radium one must know something about the atom of which all matter is supposed to be formed. The atom is a very complex structure made up of small units and is an exceedingly small piece of mechanism. A drop of water contains several million million million atoms and within the atoms are the much smaller electrons pursuing orbits, like planets, around the sun. The atom, therefore, consists of a minute nucleus made up of positive and negative electrons held in equilibrium. Accepting this view that atoms of all elements, widely different though they be in their chemical and physical properties, are built of the same material, namely, positive and negative electrons, and assuming that these are the only two constituents of atoms, the difference between one atom of radium



RADIUM APPLICATORS

A. Watch crystal containing gold seeds of radon.
B. Glass tubes of radon.
C. Needles into which glass tubes containing radon are inserted. These needles have removable ends, one of which is pointed, the other flat, and stamped with a letter or numeral for identification.
D. Platinum needle, 1 mm. in thickness.
E. Cylinders of silver, 1 and 2 mm. in thickness, employed as screens.
F. Gold capsule, 2 mm. in thickness.
G. Lead shield used to protect the eye in treating carcinoma of the skin about the orbit. When in use this is covered with adhesive plaster or gauze.
H. Brass cones, 1 cm. in height, with flange, used in treating carcinoma of the skin.
I. Aluminum frame to be covered with dental compound employed in making surface applications to the alveolar process.
J. Mold of dental compound used in giving intra-oral surface applications.
K. Trocar employed for implantation of seeds of radon.
L. Similar to K but with guard, 1½ cm. from the tip, to prevent too deep implantation.
M. Flexible trocar used in the cystoscope for implanting seeds of emanation in bladder tumors.
N. Trocar employed in implanting radon seeds in cancer of the esophagus.
O. Esophageal instrument.
P. Lead cylinder, 2 mm. in thickness, in which radon needles are placed, and finger cot used as a protector. This cylinder is used in the treatment of advanced carcinoma of the cervix by gamma radiation.
Q. Silver cylinder employed in the treatment of cancer of the cervix. The handle is a uterine sound which is detachable and there is a ring on the cylinder to which a piece of tape is fastened.
R. Applicator for intra-uterine treatment consisting of two or three silver cylinders, 1 mm. in thickness, arranged in tandem. The uterine sound handle is detachable as in Q.

S. Radium "pack"—a lead cylinder containing the radon tubes in the center of a roll of gauze 5 cm. in diameter.
T. Frame, 10 cm. high, used in treatment of the spleen and of deeply situated tumors.
U. Lead box with walls 2 mm. in thickness.
V. Assembly used in the treatment of the spleen in leucemia. The lead box U containing the needles of radon has been fastened to the top of the frame T.

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and one atom of lead, etc., is merely the difference in the number and arrangement of the electrons in the atomic structure.

Radium possesses the peculiar property of emitting unseen rays and these rays are produced constantly and in large numbers, even from the tiniest speck, as a result of some unknown action taking place in the atoms of the element. Certain atoms are continually exploding, resulting in a rearrangement of the electrons in the inner and outer systems. These atoms are radioactive—they continually emit a peculiar type of invisible rays that differ substantially from light and heat rays. Radium transforms itself very slowly into another substance called radium emanation or radon. The transformation is so slow that 1,750 years would be required for half a given quantity of radium to disappear.

Radon

RADIUM emanation or radon is a chemically inert gas, and it too transforms itself into a third substance called Radium A; but this is not all. Radium A transforms itself into Radium B, and Radium B into Radium C, and so forth, thus forming a series of substances related to each other. The last of the line of radioactive substances known to exist is Radium F, also called polonium. Radium F gives off an alpha particle and becomes Radium G or Radium Lead. The end product Radium G emits no rays, and its atoms are stable. None of these substances is a gas except the radon. Radium A–B–C deposit themselves on anything and everything that comes in contact with the radon, including the walls of the receptacle that contains it. These substances transform themselves much more rapidly than radium itself does. Half a given quantity of radon disappears in 3.85 days; half a given quantity of Radium A, in 3 minutes; Radium B, in 26.8 minutes; Radium C, 19.5 minutes, and so forth. The radon may be extracted from the radium element and pressed into a glass or metal container of any desired shape or size and the Radium A–B–C allowed to accumulate in it. Professor William Duane of Harvard has devised a machine for collecting and purifying the radon, and this method has been adopted by the leading institutions in the United States which have large amounts of radium. The manipulation of the radon is a highly technical process and necessitates the services of especially trained assistants whose measurements of its initial radioactivity and its subsequent variations can be relied upon. Radium in quantities less than a gram does not lend itself readily for radon purposes. Small quantities of the element are better put into platinum needles and surface applicators.

The effectiveness of radon is no greater than when the radium element is used, therefore, from the clinical side it makes no difference in the final result whether element or emanation is used, provided the number of radioactive units is the same during the treatment. The *millicurie* or unit of measurement in which quantities

of radon are expressed has been defined to be the quantity of radon that is in equilibrium with one milligram of radium element, equilibrium being the point reached at which the rate of formation of the gas radon is equal to its rate of decay.

One millicurie of radon possesses, therefore, radioactive intensity equivalent to that of one milligram of radium element. The advantages of the radon method appear to be

(a) that the danger of losing the radium is reduced to a minimum;
(b) that a greater flexibility is obtained;
(c) that a large quantity of radioactivity of long life, like radium, cannot possibly get lodged in the patient's system by accident.

In addition, radon possesses certain other advantages. Being a gas it is both compressible and expansible, and these qualities are peculiarly valuable in the making up of applicators, it being possible to concentrate the gas and prepare a tube of equal activity to any given radium element but only one-twentieth of its size. This is of great use in the treatment of small malignant growths or tiny nodules of recurrence, enabling an intensely powerful radiation to be given in a very small area.

Preparation of Radon

A RADIUM salt, usually chloride or bromide, is dissolved in a very weak solution of hydrochloric acid, placed in a flask, and stored in a small safe. This safe is permanently placed in a specially constructed concrete vault with burglar-proof doors. In the vault there is also located the first set of vacuum pumps connected with the radium in solution, and these pumps are connected with another set of mercury pumps outside of the vault by means of glass tubes which pass through the concrete wall; this apparatus contains the radon which is given off by the radium in solution.

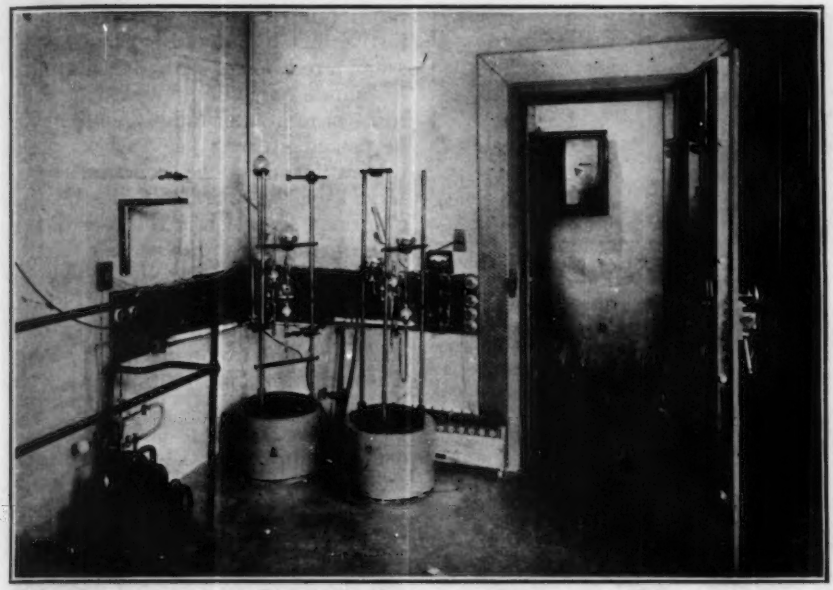
The radon is usually separated from the radium solution once in twenty-four hours. About 150 millicuries per day may be obtained from one gram of radium in solution. This amount is continually decaying, but the supply is being replenished by the machine. Measurements of the radon are not made until at least three hours have elapsed after the sealing of the radon in the tubes.

Special protection has been installed for the technicians who draw off the radon, such as powerful electric fans which are turned on before they enter the vault. The fans completely change the air and remove all trace of mercury vapors and radon. After the radon is obtained it is sealed in small glass or gold tubes of general sizes. The larger glass tubes are 0.8 mm. in diameter, 14 mm. long, and contain 50 to 200 millicuries. The smaller glass or gold tubes, called "seeds," are 0.2 to 0.8 mm. in diameter, 3 mm. long, and contain 1 to 4 millicuries. Gold seeds are more popular as they emit only a small amount of beta radiation, consequently the reaction is less severe and a slough is less likely to appear.

Radium Therapy

THERE are three different kinds of rays expelled from the atoms—the alpha, beta, and gamma—and each of these is always accompanied by delta radiation which results from the impact of any one of these with a material substance. In radium therapy we are dealing with these three kinds of radiation.

The alpha ray or particle is a helium nucleus and consists of four positive electrons or protons and two negative electrons; the beta ray or particle

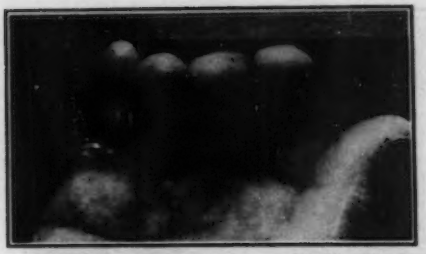


APPARATUS FOR EXTRACTING RADON FROM THE RADIUM IN SOLUTION

is a single negative electron moving at very high velocity; gamma rays are electromagnetic waves of high frequency similar to x-rays but are more penetrating. These three rays vary in their penetrating power. If radium element or radon is placed in a glass tube, practically every alpha particle is absorbed by the tube. Beta rays or particles are much more penetrating than alpha rays. This type of radiation is used for thin, superficial epitheliomata.

Filtration (screening) is very important in radium therapy. By filtration we mean the placing of some material between the source of rays and the tissue treated to cut out undesirable rays. If gamma radiation is desired, to prevent the passage of all the beta rays of high velocity, it would require 10 mm. of aluminum or 2 mm. of lead (Failla). Deep-seated tumor masses are treated with gamma rays. These filters or screens of heavy metal give rise to secondary radiation, so it is necessary to use a thin layer of aluminum, adhesive plaster, or several layers of wet gauze to remove the secondary rays.

In expressing dosage when applying radium rays, the quantity of radium or radon employed is stated, the screening, if any, the distance of the applicator from the growth, the distribution of the radioactive material over the surface of the growth, and the time of the application of the radium. Where a method of application is standardized, dosage is expressed in terms of the product of milligrams of radium or millicuries of radon used and the number of hours it is applied, the product being the so-called milligram or millicurie hours. Thus 600 mg. of radium applied for 8 hours gives a dosage of 4800 mg. hours.



Condition of fingers of nurse who had been making applicators over a period of eighteen months. Note pitted appearance of skin on finger tips, thickened cuticle near nails, and slight ulceration on second finger. This picture was taken in 1914. Tactile sense at the present time has not returned to normal and nails are still brittle.

Radium Reaction

A TYPICAL skin reaction is seen following a treatment given with unscreened or lightly screened applicator, emitting a large proportion of beta rays. It usually appears between the seventh and fifteenth days, and may vary in character from a slight erythema to a destructive ulceration. Four degrees may be clearly distinguished:

(1) Simple erythema
(2) Erythema followed by vesication
(3) Vesication with superficial ulceration
(4) Deep ulceration, generally followed by the formation of a crust, beneath which repair takes place. The period of repair varies from one to several months.

When a large quantity of heavily screened radium has been applied for several hours, there is a definite systemic reaction. Irradiation of the abdomen and lower chest often causes nausea and vomiting.

Dangers of Radiation

THE possibilities of discomfort and injury encountered by those who work more or less constantly with radium were noted while visiting the radium institutes in Europe. These institutions had found it necessary to adopt a rotation of service each month for nurses handling applicators. The tubes of radium or radon should never be picked up with the fingers. This precaution must be constantly observed, or the operator will soon feel a burning sensation in the ends of the fingers, the nails will become brittle and irregularly thickened, the skin of the fingers suffer a loss of tactile sense, thick calluses, painful ulcers, and squamous-cell carcinoma may result. These tubes should be taken up with long-handled forceps, and when not in use they should be kept in a lead container of a thickness of one inch and placed as far away from the operator as possible. Blood examinations should be made on all workers before they enter upon their duties and the effect from radium upon the blood condition of the radium personnel carefully checked up each month so that any changes which occur may be recognized at an early stage, otherwise a profound leucopenia or a mild anemia may result. Female workers may experience disturbances of their menstrual functions.

General Rules To Be Observed

1. The patient should be prepared as carefully as for operation. Tissue subjected to radiation becomes somewhat altered and has less resistance to bacterial invasion.

2. Sterilize tubes and screens.

Dip tubes in benzine for cleaning purposes, then immerse in alcohol.

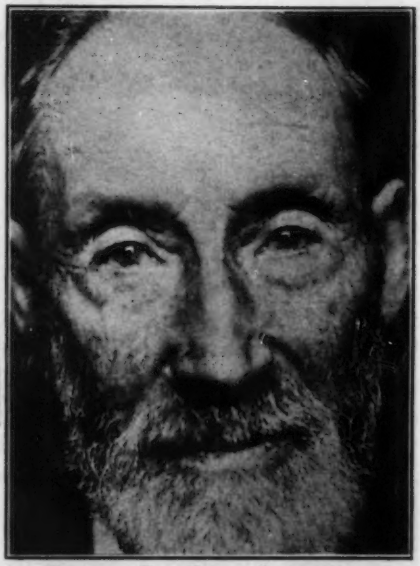
Glass tubes of radium or radon in platinum or silver containers must not be sterilized by moist or dry heat or any chemical solution that will corrode. Glass tubes in steel jackets are sometimes sterilized with moist heat but it rusts the container; the benzine-alcohol method is preferable.

Glass and gold seeds are sterilized by immersing in alcohol.

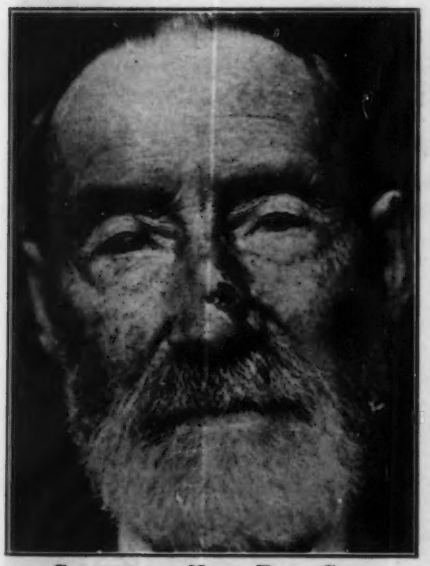
All empty containers and screens may be sterilized by moist or dry heat.

General Care

THE care of patients treated for malignant disease does not require special training. Nurses who have been taught to carry out intelligently treatments ordered and to observe symptoms will find the care of these cases no different from the general medical and surgical cases. Rest, diet, fresh air, and proper care of the local lesion are essential. Many nurses refuse to take care of cancer cases because they believe the disease is contagious. It is not contagious nor is it necessary to wear gloves when doing dressings. The same procedure is followed as when dressing surgical wounds. If the lesion has a foul odor, a few drops of oil of bergamot mixed with the ointment applied or sprinkled on the dressing will be found an excellent deodorizer. Nausea and vomiting may be relieved by giving small amounts of iced ginger ale or sodium bicarbonate.



RECEIVED TWO RADON TREATMENTS
Lesion entirely healed three months later



CARCINOMA OF NOSE—EARLY CASE

Nurses can make themselves reliable sources of authentic information with respect to the prevention, recognition, and care of cancer cases. Public health nurses have an unusual opportunity for detecting early cases which would otherwise escape recognition until they had passed to an incurable stage, and by exerting an intelligent influence on these cases they may be able to induce them to seek immediate and competent treatment. It must be remembered that treatment with radium or radon may be hurtful as well as beneficial: too small quantities may stimulate rather than retard or destroy cancerous growths. Through over-dose or lack of care in its application, radium may penetrate

CARCINOMA OF NOSE

This lesion had been treated with ointments for a long period—too late to be benefitted by radium

hollow organs, as the bladder and intestines, or do irreparable damage to normal structures. A severe septicemia may be caused by too rapid a destruction of normal or malignant tissue. During her visit to this country, Mme. Curie repeatedly stated that radium in the hands of the untrained is one of the most dangerous forces in the world, and that such a subtle element, with its all-potent strength and inexhaustible energy, should be controlled and used only by experts especially trained in its use. Radium is one of the greatest additions to surgical resources, but it should be regarded as supplementing, rather than supplanting, surgery in the treatment of disease.

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The Public Health Nurse for August

Official Magazine of the National Organization for Public Health Nursing

(May be had in combination with the *Journal*)

Editorial, High Adventure.
Relation of the Rural Nurse to the Social Work Program, Eleanor W. Mumford.
Selling Proper Nutrition to Industrial Workers, Laura Comstock.
Public Health Nursing—Indispensable and Economical for Everyone if Organized, Haven Emerson, M.D.
A Community Plan of Public Health Nursing Service for a Small City, Marguerite J. Clancy.
Climbing Three-fingered Jack, Jennet Moffat.
Outpost Stations in Finland.
Publicity Program for County Public Health Nursing Service, Helen F. Bond.
Report of the National Conference of Social Work, Laura A. Draper.
Nursing on the Labrador Coast, Bessie J. Banfill.
The Allocation of a Nurse's Time, R. H. Markwith, M.D.
Nurse! Nurse!, Elizabeth Semenoff.

Cancer of the Breast

The Sphere of the Trained Nurse in Detecting It

BURTON J. LEE, M.D.

THE nurse occupies an important and unique position in the problem of the control and care of cancer of the breast. Many women who would hesitate to seek medical counsel will turn for advice to the nurse, accepting her opinion as a final judgment in the matter. A responsibility she should not assume may fall upon her shoulders, and the advice which she gives may determine the fate of a patient. Social service activities have increased her contact with female patients. The opportunity is thus afforded the well informed nurse to teach other women in medical matters.

The nurse can give useful information concerning proper-fitting and injurious brassières and stays. She has the opportunity to teach that tight brassières and those of compression type are injurious to normal breast tissue. It has been shown that improper supports may lead to chronic inflammation of the breast (mastitis) and in some cases may be a factor in the production of mammary cancer. A brassière should be of the supporting type, fitted to the individual. Some women still persist in wearing old-fashioned high corsets, and when protruding stays impinge upon the breast, there may be caused a continued chronic irritation which may result in the development of cancer.

The need for personal hygiene of the breast can be taught by the nurse, with emphasis on the necessity for meticulous cleanliness of the nipple area, not only during pregnancy and lactation, but at all times. Disease of the gland may be fostered when these hygienic precautions are omitted. Many women suffer considerable pain in the breast just before or during menstruation. Usually these symptoms are of little significance, but occasionally they prove to be of importance. Patients with these conditions should be directed to seek competent medical examination and advice.

The nurse should teach other women that any symptom referable to the breast requires an examination by a physician. Every tumor of the breast is potentially a menace to the patient. These cases should be immediately referred to a doctor for diagnosis, for a wise nurse will never attempt to diagnose a condition of the mammary gland. Recently, a patient with an advanced inoperable cancer of breast came to my attention, a survey of whose history revealed that two years previously she had consulted a trained nurse because of a small mass in the breast, and had been assured by the nurse that the tumor was of no importance because it was *painless*. The fact is that three-fourths of the patients suffering from cancer of the breast have as the first symptom of their disease a *painless* lump. When first seen by a physician the patient in question was beyond surgery. The disease progressed rapidly, and she died six months later.

But pain may be an early or even an initial symptom of cancer, and some of the most malignant forms of the disease begin in this way. Therefore, malignant disease of the breast cannot be excluded because of the presence of pain.

The nurse should remember that, although cancer of the breast is more often a disease of mid-life or old age,

one out of every six women afflicted with this form of malignancy is forty years of age or less. Recently, a young woman twenty-two years of age appeared at the breast clinic with advanced mammary cancer. Some cases of breast cancer begin with a diffuse enlargement or thickening of the gland with no definite tumor anywhere. Only an expert can determine whether the condition is of simple or of serious import.

A discharge of blood or straw-colored serum from the nipple may have as its underlying cause a cancer within the mammary gland. Women with any type of discharge from the nipple should be directed to seek a diagnosis by a competent physician.

Irritation in or about the nipple is usually a simple matter, but Paget's disease, a form of breast cancer, begins in just this way. In its early stage it closely resembles eczema about the nipple. When Paget's disease becomes advanced, it is a serious form of cancer of the breast.

The diseases of the mammary gland are complex and difficult to differentiate. Physicians alone have the technical training to reach a diagnosis in this field. All that the trained nurse should do is to guide the patient toward sound medical opinion. If a woman, referred to a physician for diagnosis of a breast condition, returns with the report that a careful physical examination was not made, the nurse may feel justified in suggesting to the patient that further medical advice should be sought. Or if one physician says that a distinct tumor of the breast "is nothing," without advising continued observation, the nurse may justly advise the patient to obtain another medical opinion.

Finally, the most important service of all which a nurse may be privileged to render in the field of mammary cancer is to urge all women who have reached the age of thirty years to have a complete examination made by a good doctor every six months. This advice should be given even though the patient feels in perfect health. Many cases of early mammary cancer may be discovered when such regular health examinations are made, and the trained nurse will have rendered efficient service in the attempt to control cancer of the breast.

A small pamphlet, "Cancer Control—How the Nurse Can Help toward Its Accomplishment," will be sent on request to the New York City Cancer Committee, 34 East 75th Street, New York.

Consistency of Foods

OBSERVATIONS of children in nursery schools have shown that there are some consistencies which children almost invariably dislike. Stringy vegetables, such as beans and asparagus, present difficulties, and parents do not always realize that here it is not flavor, so much as consistency, against which the child rebels. It is wiser to use such vegetables in soups or purees. The food value is the same and the child becomes accustomed to the flavor and can deal with the consistency better. The cutting or ricing of vegetables aims not only to improve the chances of digestion but to overcome the child's resistance to the consistency of the new food. Creamed foods—sauces, creamed eggs, fish and vegetables—are often, though not universally, distasteful to children. If this proves to be the case it is better to avoid, for a time, serving foods in this fashion. Custards are sometimes disliked and may be avoided. It is important that children should eat eggs, but not important that they eat them in custard form. Common sense and ingenuity will help us to see that the child gets the kind of food that is necessary for him, but in a form which he is willing to take.—From "Parents and the Pre-School Child," William E. Blatz, Morrow & Co., Publishers, p. 51.

Student Adjustments[1]

FLORENCE K. ROOT

TODAY as never before the question of the adjustment of the individual to his environment is in the thoughts of educators and those who are interested in the progress of our civilization. So complex is this everyday life into which we must plunge if we are to maintain our existence as individuals! Men like Spengler see nothing ahead for this civilization of ours but destruction. We seem to have set in motion something that we are powerless to stop. I shall not argue the case with Spengler nor unhesitatingly agree. I am using his philosophy merely for evidence that the whole process of our civilization and our own adjustment to it are commanding the attention of the great minds of today.

Charles Beard says:

> The battle over the meaning and course of machine civilization grows apace, with resounding blows along the whole front. No theme, not even religion, engages more attention among those who take thought about life, as well as living; no class of thinkers or doers can go far without encountering it. A synthesis of modern aspiration, the very concept of this civilization as destiny and opportunity arrests even the witless, and especially invites all who possess the power of brains or money to stop short in their path and consider what work, under the shadow of this challenge, is most worth while here and now.

This is the sentence I want you to notice particularly: "Consider what work, under the shadow of this challenge (the challenge of our machine civilization), is most worth while here and now."

We might call this vocational adjustment and its demand is imperative. We shall consider it more carefully a little later. But now we must ask further, Is this physical adjustment, this fitting into the mechanical scheme of things, enough to ensure progress, satisfaction, and happiness?

Lewis Mumford says:

> Plainly, if human life consisted, as the new mechanists suppose, in adjustment to the dominant physical environment man would have left the world as he found it. Man's uniqueness consists in the fact that, since the equipoise he seeks involves more than his physiological balance, he has created standards and ends and purposes of his own which he imposes upon nature.

Again quoting from Mr. Mumford:

> When Mr. John Dewey says that the salvation of the modern individual lies in making his own chaotic personality conform to the corporate pattern that has been automatically created by modern technology and finance, one wonders if he can possibly be conscious of the defeatism involved in such a position.

That is, according to Mr. Mumford, man can and must create standards, ends, and purposes, that go far beyond the mere adjustment to the physical environment. And that is the second thing that I want you to notice, a creative spiritual energy which transcends the conformity to modern technology and finance.

I have quoted Mr. Beard and Mr. Mumford as a background for what I have to say that we may realize that there is or should be a philosophic foundation for our efforts toward student adjustment, and we should regard it not as a few mechanical devices to make the machinery run more smoothly during the first year of a student's life in college, but as an effort to obtain a sane, wholesome and normal reaction and attitude toward one's immediate environment, and also to start the formulation of a philosophy of life.

[1] Read at a General Session of the National League of Nursing Education, Milwaukee, Wis., June 11, 1930.

How important is this adjustment and how much should be done about it? As I have been thinking about this for the past months I have come to feel more and more that this is very important and that it needs something more than orientation lectures or "Freshman week." And sometimes I fear that our personnel work with its bureaus and records is being caught up in the same machine and I want to insert a little plea for less formal organization. We all are responsible; let's not leave it to one person entirely.

All this talk about education, how little we are accomplishing, et cetera, et cetera. Well, whose fault is it? Not the students' entirely. We must secure a different idea of what education is and how it is obtained. Sometimes I think that it is the older generation which needs adjustment to this high pressure machine age, to which the younger generation takes like a duck to water. But after all that is only the mechanical and superficial adjustment and is comparatively less important. What we want is to instill in the mind of the young person the idea that this hurrying, worrying outside world is not the whole of life—that the world of the spirit and its evaluation is of far greater importance.

Too often we make the mistake of thinking that student adjustment is different from that of other young people. That is not the case. Whether it be college or business or profession there comes a time when every young woman is thrown more on her own responsibility than ever before. She generally needs some help. One of the difficulties is that she often does not recognize any lack in herself nor any need and the help therefore must be unobtrusive and anything but patronizing.

When we speak of student adjustment we are apt to think of social adjustment. In reality there are various phases and I want to speak of four of these:

1. Vocational or economic.
2. Intellectual.
3. Social or emotional.
4. Spiritual.

I am afraid I am going to speak from my failures rather than my successes. Getting ready for this talk crystallized my idea of what I want to accomplish rather than what I have accomplished. And from now on I am going to limit my discussion to the young woman from 17 (possibly 16) to 20 who is starting upon this new profession: that is, we are dealing with the later adolescent period. Now is there any one word which can describe that somewhat incoherent state of body, mind, and soul that we find? I believe awkwardness is the key word. The head of our psychology department has been conducting some very interesting investigation of the ordinary conduct of students, and he gave me that word, awkwardness, as the keynote.

We are quick to recognize and excuse the physical awkwardness of this period. But this physical awkwardness is quickly overcome and for the most part has changed into grace and sometimes surprising loveliness by the time the girls come into our sphere of influence. But there is an economic, an intellectual, an emotional, and a spiritual awkwardness or lack of coherence that is not yet outgrown. For mere physical development does not help the situation here. The maturity must come from experience and a certain amount of knowledge and from the actual accumulation of information. Some people never seem to get beyond the adolescent stage in thinking, in feeling, and in their gen-

eral attitude toward their relation to society. We are not going to bother about them today. But what of these young people in their late 'teens who are trying to find their balance and coördinate the muscles of their minds and strengthen the sinews of their souls and harden the flesh of the spirit that it may stand the hard knocks of life and not be bruised?

Do we show as much tolerance and good nature toward this inner and more distressing awkwardness as we did toward its earlier physical manifestations? Let us consider it along the four lines which I have mentioned, and remember this—not all are awkward along all the lines. Some may have achieved a nice balance in certain lines and be hopelessly awkward in others.

Vocational or Economic

THE Freshman is generally quite at loss from the economic viewpoint. Her needs for money are many; her source of supply, small. Of the many demands made upon her by her own desires for spending, she doesn't know which is of the most importance and so she flounders. She wants so many things so very much, pretty clothes, theatres, things to eat, movies—the demand is great, the supply of ready money small, and because of lack of experience little things loom big. As a result the property rights of others are fearfully trampled upon—borrowing right and left, yes, and occasionally theft. How can we give her a sense of property rights, instill a sense of values, and a realization of the relative unimportance of some things even if everyone is doing them? Somehow she must get the idea of real democracy where personality, not money, counts and lasting friendships are of more value than short-lived popularity.

But what of the adjustment to the larger economic world? How shall I earn my living? There ordinarily the Freshman is hopelessly lost and stumbles awkwardly along, trying now this path and now that, worried and anxious. Here the awkwardness is due to her lack of knowledge both of her own ability and of the fields of occupation that are open to her.

You do not have to meet that problem of vocational adjustment except in the case of misfits for when the student comes to you she has chosen her profession. On the other hand I imagine that you often have to help the student make a quick adjustment between what she has imagined the nursing profession to be and what it really is. And at this point I can give you no advice. I can only take off my hat to you and wish that I could get across to my students the idea of what education in a liberal arts college really is, as quickly as you imbue your students with the professional attitude.

Let me stress the importance of this professional attitude—whether it be nursing or business or teaching—the lack of it so often hinders a girl from the advancement she would otherwise make. We should use every possible means to do away with that bad habit of taking everything personally. I feel that student government and student authority are in no way successful until penalties can be imposed and received without jeopardizing the friendship of those involved and it is valuable in so far as it helps a girl to recognize that she is a part of an organization and responsible for the welfare of that organization.

In the same way the suggestions and criticisms of some older person, someone in authority, may be valuable not only for the immediate reaction but because it should accustom her to

taking suggestion and even criticism, understanding that the friendship is no less strong. And while we are about it, let us try to help the oversensitive and thin skinned to feel hurt less often.

Another necessary element is pride. Pride in one's profession is essential for any satisfaction.

Remember what Mr. Beard said—"the very concept of this civilization as destiny and opportunity . . . invites all . . . to stop short in their path and consider what work under the shadow of this challenge is most worth while here and now." Can you make your student feel that she has chosen the most worth-while work? Then her success is likely to be swift and permanent.

Intellectual Adjustment

HAVE you ever been exasperated beyond words by the reasoning (so-called), the arguments of your students? I have. But after all, isn't it just that their reasoning processes are still in the awkward stage? They haven't control of the process yet. Or perhaps they haven't the necessary information. They don't know the facts, but that doesn't prevent their arguing. They love it. They like the mental exhilaration that it gives, a sense of intellectual might and power. And they are keen too. I believe if we can just remember this awkwardness, we shall be less inclined to exasperation. We can afford to present the facts somewhat more carefully and point out defects of the argument while we respect the ingenuity that it represents. Sometimes the manifestation of this awkwardness is quite different; there is the laziness and indolence and lack of fire and energy which we deplore but which should be a challenge to us to wake up this clumsy, awkward mind.

The Social Side

NOW what about the social side? Probably here we find the most obvious manifestation of the awkward age and perhaps here we can be most useful in our adjustments. If any girl is to be a success and go with self-confidence about any chosen profession, she must feel at ease in her surroundings. She must be so sure of how to conduct herself that she can give her mind to other things. You have in your nursing a certain amount of professional etiquette which must be observed. I wish we were as strict about the ordinary social observances. I think we have no right to let our students be handicapped all through their course and, in fact, all through their lives, because they do not know how things should be done. In every dormitory or house there should be some woman of pleasing personality to whom that task belongs. It can be done without offense to anyone. In fact, I find that girls are most eager to find out what is the proper way to do things and are grateful for information, and in later years they are appreciative of whatever insistence there has been on the observance of good form.

What about social adjustment in a somewhat broader sense? How are they all going to learn to live happily together with the least amount of friction, heartbreak, and hurt feelings? The shy girl who is really charming but doesn't know it: how shall we bring her out? The girl who is as good as gold but altogether lacking in personality and really unattractive: can we help her overcome that handicap? The girl who is over-emotional or over-restrained?

I know from experience that there are two especially effective means of bringing about this social adjustment. First, through the head of the dormi-

tory or house in which students live, if she is a woman with tact and personality and good sense, and an interest in her group. Second, and even more effective, through a group of upper-class girls.

Perhaps it will be worthwhile to tell you somewhat in detail about my Senior Counsellors. They are the twelve senior women chosen by the whole student body, who are considered to be best suited to take charge of a group of freshmen. These girls meet their freshman groups once a week for the first few weeks and then every two weeks. They aim to know them well personally and see that they know each other. They stand ready to answer any questions, to discuss any subject, and find out the difficulties.

This group meets with me each week before having the discussion with their freshmen and in this way I can keep in touch with the freshman girls and smooth over difficulties that otherwise I would know nothing about.

Creative Spiritual Energy

AS WE take up our last point—that inner or spiritual awkwardness that demands adjustment—I want you to recall the creative spiritual energy that I spoke of earlier which creates standards and purposes that go far beyond conformity to the physical and mechanical environment in which we live. After all that is the kind of adjustment we want for our students, isn't it? A steady and individual growth, a purposeful development of latent possibilities, an inner adjustment to the joys and sorrows of life—its successes and failures, a growing appreciation of life's opportunities, a deepening and enrichment of life, a realization that education goes on after the training is over.

Can we do anything to bring that about? Yes. Not a great deal perhaps, and not in the lives of many students, but occasionally and imperfectly we achieve something of what we are after and then we know that it isn't a fruitless task we are undertaking. In these few cases lies our great reward, the joy of the work.

Before I stop I want to make a few very practical suggestions of ways and means for making these adjustments. You will notice that I have talked entirely of the normal, average student. I purposely have avoided the cases that demand more than an elementary knowledge of mental hygiene. What we might call the "problem" cases are so widely discussed in these days and their treatment by specialists could be so easily obtained by you through your hospitals, that I have not felt it necessary for me to discuss this.

To return then to the adjustment of the average student and the ways and means of doing this. In this whole matter I believe very strongly in any conferences or committees that will bring the older women and the younger together to talk things over. That division that rose up suddenly between the two generations soon after the war was most deplorable.

I believe that we of the older generation were largely to blame. We were afraid of this lively, energetic, somewhat cynical and altogether independent group. We feared their criticism and to avoid this I think we were too prone to lower our standards, to condone much because every one was doing it. We were not sure of ourselves. There seems to be every indication now that both groups are seeing the need of each other. It is much easier now for us all to work together and I think that any form of dormitory or college government should be coöperative rather than divided. That is the truly democratic way.

We say that the younger generation must make their own mistakes. That is only partially true. They must make their own decisions and sometimes these will be mistaken ones, and when the mistakes are once made we must not be too harsh. But we can and should do our part in setting up standards, in giving them a right sense of values, in surrounding them with the best influences during these formative years. When the time for decisions comes we cannot and probably should not have very great influence but we shall have done our part if we have given them some sound basis for their decision, and some standards by which to form their judgments.

Now as to ways and means. In the first place and of prime importance, there must be some older person who is primarily interested in this. She may be some administrative officer, some house director—whatever your scheme of organization suggests.

In the second place, we cannot expect the student to take the initiative. In the obvious cases of lack of adjustment, don't be afraid to act, let it be through whatever channel seems best. I mean, don't be afraid of interfering and of hurting feelings. I find that I have regretted the failure to come forward with the helpful suggestion far more than any over-zeal. But the trouble is that there may be serious cases of lack of adjustment, such as to cause unhappiness, that could be remedied if we knew about them. But we are quite unaware of their existence. For that reason I think that there should be regularly assigned personal conferences. If the person conducting the interview is sympathetic and on the watch, it is amazing the number of unexpected things that will come to light—interests, hobbies, worries, disappointments, and ambitions. Then don't try to meet all these yourself, but have others help you. And this brings me to my second point. There must be a large group to help you. Of great importance I consider the heads of your student houses. The influence of the atmosphere of the house in which the student lives is most far-reaching. That is a channel for student adjustment and development that is often given far less importance than it should have. Use your faculty as assistants. Have upper-class students who are working with you to orient the freshmen. I cannot over-emphasize the value of such a group.

Remember that the adjustment comes from within and cannot be superimposed. I happen to know well one outstanding example among educational institutions where the cultivation of the inner spirit is made of paramount importance: the Clark School for the Deaf. They create a spirit of contentment and courtesy and take away that suspicious attitude that is apt to be found among the deaf. I know they begin training when they are young, but think of the handicap. Can't we do as much for the normal girl?

And as my last word to you—this adjustment is not just for the freshman year or while the girl is in training. It is her adjustment to life. During these years of training the lines along which she is to develop are becoming well determined. There are many phases which she may outgrow—lack of confidence, over-sensitiveness, or on the other hand cynicism and intolerance. But the foundation for future growth must be laid during her training. And when education and experience have done away with awkwardness and brought her to maturity of mind and spirit, she is grateful if she can feel that she has a firm foundation on which to build.

Two Common Diseases of the Skin of the Feet

H. H. HAZEN, M.D., AND FLORENCE B. BIASE, R.N.

THERE are two common diseases of the skin of the feet which cause much discomfort and concerning which there is still much ignorance even among physicians and nurses; namely, ringworm and plantar warts.

Ringworm of the feet and hands was forcibly called to the attention of the medical profession of America in 1915, by Ormsby and Mitchell, and since that time it has been generally recognized by dermatologists. At the present time many of the laity have some knowledge of the disease. A superfluity of names has been given: dermatophytosis, acute eczematoid ringworm of the hands and feet, as well as "sand blisters," "mud feet" and the like.

This disease is probably the commonest one in the world. At the medical department of the University of Pennsylvania, over sixty per cent of the students were found to be affected and at Leland Stanford the percentage was even higher. Attention should be called to the fact that the disease is essentially one of the better classes of society, for in dispensary practice it is not especially common, while in private practice a routine examination of the feet will show at least thirty-five per cent of all persons past the age of twelve to be affected. In the Navy, this disease is the greatest single cause of disability among crews on tropical duty.

In the vast majority of instances some one of the large group of ringworm parasites is responsible, but at times a yeast or even some of the common bacteria may be causative. The ringworm organism belongs to a low order of plant life and is classed among the fungi. But little is known of the life of the parasite outside of the human body, although it can live for months in dried epithelial scales.

In certain cases the body possesses a considerable degree of immunity against the invader, but one attack does not guard against subsequent ones. Children under eight years of age practically never acquire the disease. The organisms affecting the toes do not attack the scalp nor do they invade the hairs or the hair follicles. Likewise they never affect the face and very rarely the body. The ringworm organisms do grow deep down into the skin, and this is the reason they are so difficult to kill.

In many instances the disease is by no means a mild one. In 161 consecutive cases which we studied, fourteen persons were totally disabled for from two to sixteen weeks, and thirty-two were partially disabled.

A number of clinical types can be recognized: the first is where there are cracks or scales between the toes, with an occasional felt-like pad between the fourth and fifth toes. The second type is where small or large blisters develop upon the soles of the feet, the dorsal surface of the toes or even the ankles. Similar blisters not infrequently develop upon the insides of the fingers or even upon the palms. New crops of blisters may appear at frequent or at infrequent intervals. The third type is where there is a more or less diffuse scaliness of either the palms or soles, combined with a few vesicles. The fourth type is the hyperkeratotic one, with thickened masses of hard dry skin, usually upon the soles. The fifth type is the most severe and in this there are large raw areas with much weeping and oozing.

Various combinations of the above mentioned types can be found.

The more frequent complications are: first, involvement of the nails with cracking and splitting of the nail substance and a piling up of the nail bed; second, soft corns between the toes; third, secondary infection with numerous pustules; fourth, involvement of the draining lymph nodes; fifth, ringworm of the groin or axillae; and sixth, spread of the eruption to the forearms and lower legs.

The absolute diagnosis of ringworm is dependent upon the finding of the organism, either by smears or cultures, but this method is difficult except between the toes. Yeasts or bacteria may cause similar interdigital lesions. Blisters produced by poison ivy or the house primrose may have a superficial resemblance. In fact irritation produced by almost any type of external irritation may closely simulate ringworm.

Apparently the disease is most common among those who use a common dressing-room. Hence the frequenters of golf clubs, swimming pools and gymnasiums are almost invariably affected. In fact the disease is sometimes spoken of as "club foot." Household epidemics are also common. This may well be due to the use of a common bath mat, or to the exchange of stockings or bedroom slippers, to walking barefooted, or to the use of a common towel. Attacks are most frequent during the warm weather, and the wearing of wool stockings seems a marked predisposing cause. The disease could be readily contracted upon the hand from door knobs, steering wheels, street-car straps, gloves, or from holding hands.

An individual affected with ringworm should not use a common bath mat. It is much wiser to step upon a section of newspaper, which should then be burned, or to employ a towel. Towels and soap should be kept separate and a special towel should be employed for the diseased areas, lest the infection be spread to other portions of the body. The stockings, shoes, slippers and gloves of a person with ringworm of the hands or feet should be worn by no one else. The use of light canvas slippers in common dressing rooms would probably result in a marked decrease in the frequency of the disease. The floors of these dressing rooms should be washed frequently and treated with antiseptic solutions. A person with acute ringworm should sleep alone. In the presence of lesions upon the hands one should not dance, drive a car, or hold to car straps except when wearing gloves.

Practically every known antiseptic has been used for the treatment of ringworm. It is possible to mention only the therapeutic methods which have yielded us the best results. There is no type of serum which produces the slightest improvement. Infected areas should be soaked once or twice a day in warm normal saline solution for at least fifteen minutes. Very light doses of x-ray often aid in speedy temporary resolution, but apparently not in permanent cure. Two treatments a week with the ultra-voilet light constitute a better and safer method. The well-known Whitfield ointment should be used once or twice a day upon all dry affected areas. The formula is

Salicylic acid	
Benzoic acid aa.	dr. 1
Lanoline	dr. 1
White vaseline qs. ad.	oz. 1

Mf. Ung.

This ointment must be used very lightly at first and never immediately following a bath or soak. Where

there is oozing, a ten per cent solution of mercurochrome in equal parts of alcohol and water, or a three per cent solution of gentian violet in alcohol and water is to be preferred. Between applications, calomel powder should be used. Inasmuch as the organisms gain a tolerance to any one drug, it is wise to shift the remedy used once in two weeks.

By adopting the above method of treatment, over ninety-nine per cent of all cases can be cleared up and at least fifty per cent cured. Because of the prevalence of the disease, many so-called recurrences are probably reinfections.

Plantar Warts

PLANTAR warts are simply ordinary warts that have developed upon the soles and which have been forced into the skin by pressure. They are not so frequent as are warts of the hand, but are far from uncommon. Epidemics in girls' schools are not unusual, and family epidemics are common. For some reason school epidemics among boys are very rare. Warts are due to an unknown type of organism and are auto-inoculable and somewhat contagious.

Plantar warts may be either solitary or multiple. As many as seventy-five have been encountered upon one foot, and the presence of five to twenty is not rare. Warts are most frequent upon the ball of the foot and the sole of the heel is also frequently involved. The solitary warts may vary in size to one half inch in diameter. During the first year of their existence they are extremely painful. In the attempt to relieve pressure upon them, various types of foot strain may be induced. They are frequently mistaken for corns or calluses, but pressure upon them will promptly tell the difference, for the wart is much more sensitive.

Persons having plantar warts should not use common bath mats nor should they permit others to wear their stockings. They should not go barefooted, but should wear canvas slippers. The method of election for the treatment of plantar warts is either x-ray or radium, and there is little to choose between the two agents, although an occasional wart will yield to radium when it stubbornly resists x-ray. The treatment must be heavy and confined to the wart alone. If the x-ray is employed, no filter should be used; but with radium some filtration is essential.

In the case of multiple warts, where large areas must be treated, it is necessary to employ small doses. One of the most striking effects of x-ray treatment is the relief from pain which usually occurs about five days subsequent to the first treatment. Treatments are given at intervals of four weeks, and from two to three are usually necessary to effect a cure. We have seen no bad effects from treatment, save in one case where a roentgenologist treated a large area too intensively, and a few telangiectases resulted. A protective pad may be worn if it gives comfort, but no medicine should be used upon the wart. Over ninety-five per cent of permanent cures have resulted from this method of treatment.

Excision with the knife results in temporary disability and is followed by a scar. In addition, recurrence of the wart is only too common. Treatment with acid or silver nitrate is very painful and frequently ineffective. The use of the electric spark is painful unless the local anesthetic be very well given and always results in several weeks of disability.

Saving Labor in the Plaster Room

MARGARET NORRIS, R.N.

FEW tables are long enough to provide adequate space to stretch out an especially long, moulded plaster splint, and so to answer this purpose I have adopted a "splint board." This board is an ordinary board 60 inches long, 6 inches wide and 1 inch thick, covered with white oilcloth. It provides the necessary length and may be placed on any table or sink. Being covered with the oilcloth, it is easily cleaned; it is not heavy to handle and may be stored in a small amount of closet space. It is especially convenient to take to the bedside of a patient who cannot be moved to the plaster room.

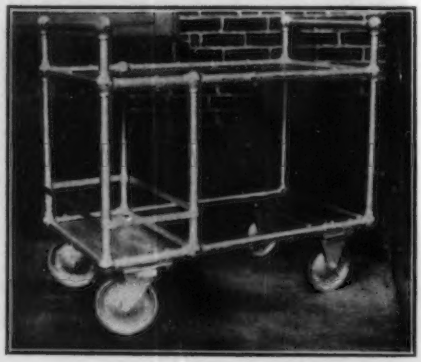
Linings made of maroon rubber sheeting, which fit inside the buckets in which the plaster bandages are dipped, are great time- and labor-savers. These linings should be made a little larger than the inside of the buckets and deep enough to allow a cuff to turn down over the top.

A thorough oiling of all the equipment used in the plaster room prevents the plaster from sticking to it. This is especially true of the Hawley table, scissors, knives, etc.

A Ward Cart

WHEN it was found, at Peter Bent Brigham Hospital, Boston, that wheel chairs were being used to transport every conceivable kind of article, a cart was devised as shown. These carts are used for transporting linen, soiled linen, blankets, basins and water, and for many other purposes. A small enclosed shelf for urine specimens has been provided on the lower portion of the cart.

The cart is made of steel pipe and railing fittings. It is 5 feet, 6 inches high; 4 feet, 4 inches long; and 24 inches wide. The frame extends above the platform which is made of one-half inch ash slats. The cart is equipped with two stationary and two swivel-plate, eight-inch rubber-tired wheels. The entire frame is painted with aluminum paint which gives a very nice appearance.



A Venereal Disease Clinic

An Experience in Adaptation

ELLA M. RAFUSE, R.N.

AS an aftermath of the war, many states realized, as never before, the prevalence of venereal disease, its sequelae, mental, physical, and social, and the need to control it for the good of the individual and the race. Massachusetts was one of those states. An appeal for help to the hospitals met a fair response.

It so happened that a hospital in which the writer was working was among those which became interested, and I had first-hand experience in the matter. It worked out somewhat as follows.

The Project

THE State Department of Health sponsored and put through a bill providing for a bonus of $1,000 per year to each established hospital or dispensary (one in each town of 10,000 or more people) which would open and conduct a clinic for venereal disease treatment and prevention. The salary of the doctor in attendance, a purely nominal one, was the concern of the state. All other expense was to be met by the hospital until the clinic could be made self-supporting.

A flat rate of fifty cents to one dollar per visit, including all necessary treatment, was made the standard, but all comers, whether able to pay or not, were required to be admitted and given treatment. If a patient were able and willing to pay more than this amount, but unable to pay full medical fees, that also was not only permitted but advised.

Arsphenamin was furnished free by the state. Other supplies were to be cared for by the hospital if clinic returns were insufficient. The clinic was also to be the center for distribution of free arsphenamin to such doctors in the community as wished to use it, thus cutting down rates to patients proportionately.

The Situation

THE hospital was a general hospital of 150 beds, and had no outdoor service except a monthly clinic conducted by a Boston orthopedist, under the auspices of a semi-public association for the care of children. The hospital furnished the room and nursing service for the clinic itself. Any patients recommended for hospital treatment were paid for at regular rates by their parents or by the society. Hence the service could hardly be considered dispensary work. This hospital was chosen for the clinic partly because of its success in the above-mentioned clinic and partly because the doctor appointed by the state to take charge of the venereal work approved of its methods.

It was a limited staff hospital, taking all kinds of patients except those usually handled by a contagious service and chronic cases. The staff was permitted to extend the courtesy of the hospital to a few doctors who were, in its opinion, capable and desirable. This arrangement resulted in between fifteen to twenty men and women who sent patients with more or less regularity. Theoretically, at least, it was not a charitable institution. In practice, however, although each patient paid or was paid for, there was practically always a deficit which had to be met by the board of trustees. They were charitably-minded, of course, but they were also business

men and, as such, were unwilling to have the hospital take on outside responsibility without some reasonable hope of its successful discharge.

Problems

WHEN the situation was first discussed with the superintendent, the following problems presented themselves:

1. Is the clinic really needed?
2. Where shall we get the beginning essentials for it, *i.e.:*
   (a) Proper quarters consisting of at least two, preferably three, rooms.
   (b) One nurse assistant for the female clinic.
   (c) One orderly assistant for the male clinic.
   (d) Necessary equipment—furniture, instruments, sterilizing facilities, drugs, linen, etc.
3. Will $1,000 cover these expenses?
4. Will there be enough patients to make it at least approximately self-supporting?
5. How shall we reach these patients?
6. How shall we arrange for as little publicity as possible for them, since that will be a big item in their minds in deciding to come?
7. Does the community want it?
8. Can it be made to care for such private patients as have formerly been received and treated, at some inconvenience and much expense, in private rooms under the supervision of the operating-room supervisor, who objected to the additional work as too much for the already sufficiently busy staff of nurses under her charge?
9. There was also the additional consideration that it would get this type of patient more or less out of the hospital proper in deference to public opinion.

Solution

The questions were answered as follows:

1. Is the clinic needed?

We had had many cases on our own wards, and doctors had reported unofficially a fair number among their patients. There were many more cases reported to the state department as coming from this city, although names were not available, since cases were reported by number only. There was no known means of treatment either here or within commuting distance for those unable to pay regular medical fees, which varied from fifteen to twenty dollars per treatment and at times were as high as fifty dollars.

The answer was obvious—the clinic was needed.

2. Where shall we get essentials?

Adequate quarters:

Some accommodations within the hospital proper were at first considered, but there were two objections to this:

   (a) The building was already taxed to its limit.
   (b) It was thought, by some, that such a clinic in close approximation to other services might militate against the use of the institution so as to cut down the other clientele.

There was, however, back of the hospital and some fifty feet distant, a building put up in army-barrack form during an earlier poliomyelitis epidemic and at this time not occupied. It had running water, electric lights and gas throughout, and steam heat in part of it, but it was evident that an appreciable sum would have to be expended to make it usable, although the general plan was such that it could

be adapted to the purpose under consideration.

3. Service.

This item, it was thought, could be arranged by a small extra payment per month to one supervisor and one orderly who could carry on the clinic at least for a time.

Furnishings. These also presented little difficulty in a hospital where there was a storeroom of discarded operating-room furniture, chairs, tables, and so forth, which had been replaced at various times by more modern equipment. It therefore appeared that $1,000 would cover expenses, provided it did not cost too much to remodel the old building.

4 and 5. Patients.

It seemed reasonable that through the doctors on the staff, industrial nurses in the mills and manufactories, the District Nursing Association, and the Board of Health, and with the coöperation of the state department in the matter of notification, we might hope to reach a fair number. We hoped that these would make a nucleus. The prospects seemed favorable. Placards in public places were also considered, but it was feared by some that this might not be wise because of the influence of publicity on the present clientele.

6. Privacy.

It was late fall and became dark early, so it was thought that there would be less publicity with an evening clinic until it was well established. The fact that the building was back of and had an entrance separate from that used for ordinary hospital visitors also helped. Thus the only big difficulty was to get patients without too much difficulty or publicity.

7. Does the community want it?

The question of the attitude of the community was one of which no one was sure, but the fact that it was forward-looking in child care, school hygiene, milk and food inspections, and so forth, seemed hopeful.

8. Could it be made to include the care of private patients of this group?

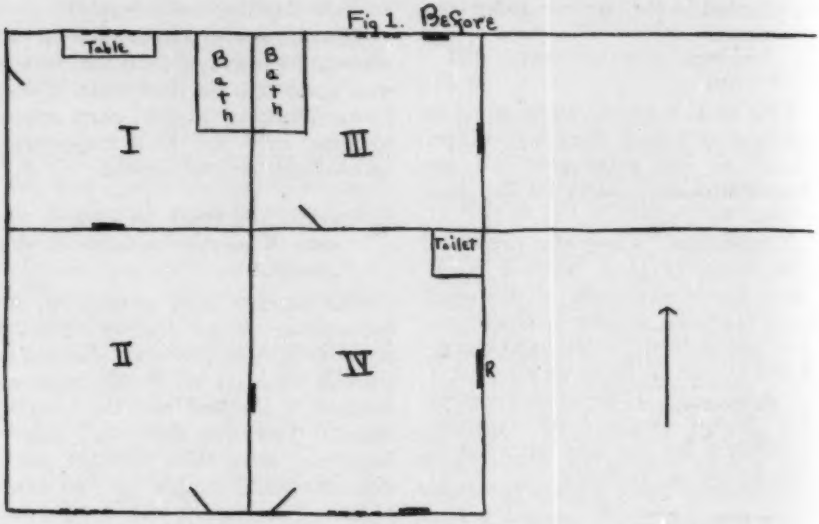
This seemed most possible if the coöperation of the doctors could be secured. It was, therefore, decided to present a statement of the proposed venture to the staff and the hospital board. This was done, and simultaneously, since their monthly meetings happened to fall on the same night. The impact was terrific, because no one had foreseen such a storm of protest. The hospital board objected on two counts:

1. It would involve some expense, for they were sure that there were not enough patients of that type to help to any extent with the finances, since "there could be only a few anyway, and those few of a class which could not pay."

2. They believed that it would ruin the hospital in the eyes of the paying class of patients in the city to have a clinic of such a sort in connection with it, especially since the community would not understand that contagion, if properly handled, can be controlled.

The staff agreed with these statements, although expressed in slightly different language and added that:

1. They were sure that it would hurt the prestige of the hospital to such an extent that many of their wealthiest patients would be diverted to a new private institution just established in the city, to which no one



but the man who owned it could send patients. That is, they felt that both hospital and doctors would lose money, prestige, and patients.

2. While it might be possible to get the poorer class (free) patients to come to such a clinic, the better class (the paying patients) would never come to such a segregated place because of the stigma attached. Thus the removal of this type of patient from the hospital would not be facilitated.

3. The service given in such conditions could not even approach that given under the present arrangement to paying patients.

4. This clinic would attract people who could pay and, by free service, detract from the clientele of the various doctors.

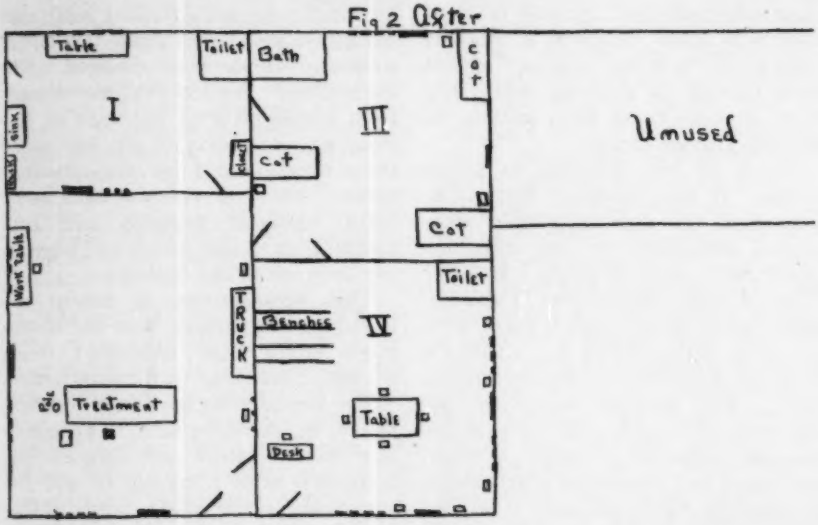
In spite of objections, however, and after both staff and board had been made to feel that it was hardly advisable to "buck" state authorities, particularly since they threatened to give the clinic to the one rival institution in the city, they grudgingly admitted that "it could be tried."

The position of assistant fell on the writer, partly because I was interested enough to want to see it go through and partly because no one else would consider handling such a clinic. One of the orderlies who had been in the navy agreed to take the male side, and preparations were begun.

An estimate of $500 was accepted for remodelling the old building, and the budget for the first year appeared as follows:

Building	$500
Salaries (extra)	240
Supplies (new)	100
Heat, light, sterile goods, sundries	160
Total	$1,000

The floor plan as it was and as it was remodelled appears in Figure 1 and Figure 2. All rooms had gas and electricity. Rooms I, III and IV had steam heat. Room II was used as a storeroom and had light but no heat.



Dotted lines show windows. Heavy lines represent radiators.

The floors in the remodelled building were covered with linoleum that had been relegated to the storeroom when hard wood floors had been installed in one wing of the hospital not long before, and the walls were of weatherboard. Windows and doors were screened in the old building. Some of that screening was found to be good enough to use.

Room I was taken as a workroom. The outside door was fitted with a lock but left so that it could be opened, if necessary, for ventilation. The partition between I and II was moved in about two feet. The sink was left unchanged. A work table, 10 by 2½ feet, was built under the window against the north wall and a three-burner gas stove, found in the storeroom, was installed. A rack for urinals, both male and female, was hung in the southeast corner, and with a chair or two and a row of hooks for gowns, the doctors' coats, and so forth, completed the furnishings. An old wardrobe which had been used for former occupants was painted and some shelves were added for linen and supplies. The bathroom was converted into a small toilet, the remaining floor space being thrown into the room.

Room III was to be a rest room after treatment. The partition between rooms III and IV was moved south 4 feet, giving floor space 20 by 32 feet. There was only one window, and ventilation was a problem, but it was the best we could do. Three cots, three tables, and three rows of hooks were installed and a door cut through into room I. There was a door between room III and room IV which could be used if necessary, but was usually kept locked to prevent intrusion from the waiting room. The bathroom was left, and its racks were used for utensils. The cots had plain, washable covers on the mattresses and washable cotton blankets for use next to the patients. Woolen

ones were provided in case of need and were aired (outdoors if weather permitted) between clinics. There were enough so that we would not have to take them from patient to patient without airing.

Room II was assigned to treatments. It was unheated, but radiators from the unused portion were moved according to the diagram. Doors were cut into rooms I and IV. There was also one between II and III which could be left open if there were a patient in the rest room, so that he could be watched from the treatment room. Two windows were made on the west side and a table to work on was put under one of them. A truck was found and renovated which could be used to move patients if necessary. An old gynecological table was painted and utilized as a treatment table, being equally convenient for the administration of arsphenamin and for vaginal and rectal examination. No gravity pole was available, so one had to be bought. It was also necessary to buy a fish kettle for sterilizing instruments. The graduates and gravity apparatus in use in the main hospital for such treatments were transferred, with two small tables. The same was true of a fairly good stock of linen and towels. Sponges, sterile gauze, towels, and so forth, were obtained as needed from the operating room, record to be kept and charged against the clinic account. Drugs, except arsphenamin, were handled in the same way. Hooks were furnished here also for hanging garments during treatments, since it would hardly be safe to let them stay in the waiting room.

Room IV was partitioned off to be 18 by 20 feet, and benches were bought and installed. There were also nine plain chairs, salvaged from the storeroom, and a big center table on which were put a reading lamp and discarded magazines from the house patients, which were changed after each clinic. We felt that the danger from contagion with the type of patient we were likely to get was more than overbalanced by the pleasure given. All windows were hung with plain washable curtains and furnished with shades which had been in previous use in the building.

This arrangement of rooms allowed for free passage from one to the other around the treatment room without interfering with its activities.

The remodelling cost $460, leaving $40 for incidental repairs. The necessary new furniture and supplies totalled $60 with a margin of $40 for any needs which might arise. This, with the $160 for heat, light and sundries, we thought should carry through until we had at least a part-pay clinic.

Clinics were planned for two nights a week, one for men and one for women. Patients came slowly at first, since the board and staff still refused to countenance the posting of public notices. The first ones came through the Department of Health of which our doctor was an official. Some also came from the factory at which he was a visiting man. The Visiting Nurse Association coöperated, as did some of the doctors. These patients sent others until, at the end of six months, we averaged about eight patients per clinic and found that all we could manage in two hours with the limited staff.

The treatment was carried out according to state recommendation and was as follows:

First visit—Wassermann taken and as much history as possible obtained.

Second visit—If the first Wassermann were negative, the patient was required to have a second for verification. If it was still negative and symptoms had not subsided, he was referred to his own doctor or, if unable to pay,

to the city physician. (The Wassermanns were done at the state laboratories.) If the Wassermann were positive, treatment was begun at once. It consisted of arsphenamin, six doses, and mercury in oil intramuscularly, ten doses. The first six of each were given together at intervals of a week. Then followed four mercuries, one each week, and on the eleventh week another blood test was taken. This arrangement made it possible to count on seeing patients once each week and made the follow-up work, which was taken on by the Visiting Nurse Association, somewhat less.

Whether the Wassermann were negative or not after the first course, a second was given. It was treated simply as a check on the progress, if any, of the disease. If negative after the second course, the patient was discharged and told to return in a month or sooner if symptoms recurred. If they did not return, the Visiting Nurse Association was asked to look them up and report.

Gradually the doctors began to use the clinic room for private, paying patients. Some tried giving treatments in their own offices or in homes, after the hospital service was discontinued, but found it unsatisfactory. These fees supplemented the returns of the clinic sufficiently to pay extra salaries and expenses. At the end of the year, the clinic was functioning four nights a week; the doctor and I each had an assistant; we were handling an average of forty patients a week, over half of whom were paying full clinic fees; and best of all, the staff and board were coöperating to send patients, for they were convinced that no harm had been done to the hospital by the clinic, that the community was being served, and that the clinic was at least self-supporting and might sometime show profit.

Preparation of Sterile Solutions

Method Used at the Christian R. Holmes Hospital, Cincinnati, Ohio

STANLEY DORSEY

THE method of preparing and labeling sterile solutions in flasks at the Holmes Hospital was developed, several years ago, in the pharmacy of the Cincinnati General Hospital. The purpose was to produce a solution containing a minimum of foreign matter and to reduce the possibility of mistaking one solution for another. It ensures a greater degree of safety since only one person —the pharmacist—is responsible for all the solutions from the time preparation is started until they are ready for dispensing.

The procedure is as follows: About 1500 cc. of the solution, made from C. P. chemicals and filtered to a brilliant clearness, is filled into each 2-liter flask on the etched portion of which the pharmacist marks a code letter by which he can later distinguish the solution for labeling.

A single sheet of No. 40 powder paper is placed over the mouth of the flask and crimped down over the lip. The purpose of this paper is to prevent fibers from the cotton, later used, from falling into the solution. A double thickness of dressing gauze, cut into 6-inch squares, is covered over this paper and is also crimped down over the lip of the flask. The cap thus far made is then perforated with a num-

ber of pin holes to allow the escape of steam during sterilization. These may be made, in one operation, by a number of pins pushed through a thin cork stopper. A layer of non-absorbent cotton, large enough to extend down over the lip of the flask is then added. On top of this cotton is placed a small piece of indicator paper which is used merely to indicate whether or not the flask has been run through the autoclave and does not indicate that the solution is sterile. This paper is red when put on the flask and after having been sufficiently heated turns black, due to oxidation. The following is the formula for the indicator ink used in painting the paper:

Silver nitrate	15.0
Potassium nitrate	15.0
Ammonium hydroxide 28%	60.0
Sucrose	4.0
Acacia	4.0
Carmine No. 40	1.0

The cap thus far made is then covered with another double thickness of dressing gauze, the whole crimped down over the lip of the flask and held secure with two or three wraps of one-half-inch bandage gauze, tightly tied. The portion of the cap which extends below the wrapping is finally trimmed off. The flask of solution is then ready for sterilization.

After the solutions are sterilized, a flask, picked at random from each lot, is submitted to the laboratory for examination. When the solution is reported sterile, the lot is then labeled. A different colored label is used for each different kind of solution and the paper cap used corresponds in color to the label. (A list of these colors and the solutions they represent will be found at the end of this article.)

The procedure in capping and labeling is as follows. One of the large paper bottle caps is placed over the top of the flask, crimped down, and held by a rubber band. Over this cap is placed a strip of white paper, about ½ inch wide and 8 inches long, which is carried down and pasted to the neck of the flask on each side. On this strip is printed, "Sterilized for 20 minutes at 20 pounds." Around the neck of the flask and covering the ends of the strip is then pasted the label. On this label is printed the name of the solution, the strength, and the expiration date.

This system, although simple, has proven to be efficient and safe. By a glance at the color of the cap and label, the user can distinguish the solutions. In order to use the solution, the strip over the top of the cap has to be broken. Also the style of closing the mouth of the flask guards against the use of contaminated solutions, since there is no cotton plug in the neck of the flask which might be replaced after the flask is once opened and part of its contents used. In addition to the safety, the completed flask of solution presents a very finished appearance.

The solutions and corresponding colors are:

Physiological salt solution	Green
Glucose solution	Yellow
Fischer's solution	Red
Boric acid solution (not for intravenous use)	Blue
Sterile distilled water	White

Working Relationships between the Hospital and the Private Duty Nurse[1]

E. I. ERICKSON

THE private duty nurse occupies a unique place in the care of hospitalized patients. She is not a regular member of the hospital organization, but she is called in when the condition of a patient is such that constant individual care is needed. True, there are many patients who insist on having such care even though it is not an actual necessity. At times this may be a mere matter of pride, but there can be no question that it is after all the most nearly ideal care, because the nurse can give all of her attention to one patient instead of dividing her time among several, as is the case when on general duty.

Although the private duty nurse is auxiliary to the permanent hospital personnel, she is, nevertheless, a very important factor in the work. The hospital cannot afford to make her a part of its regular organization because of the wide and rapid fluctuations between maximum and minimum demand. Care by private duty nurses is expensive to the patient and, except when they are most critically ill, comparatively few can avail themselves of this service. But for those who can afford the extra expense it is well worth it.

In recent years we have noted the growth of graduate group nursing as an effort to furnish a modified type of graduate care at somewhat less cost to the patient. It seems to be meeting a definite need, but it will not supplant the private duty group, because many patients will not be satisfied with anything short of individual care.

[1] Read at Registry Round Table No. 1, Biennial Convention, Milwaukee, Wis., June 12, 1930.

Private duty requires a versatile individual who is able to adjust herself to varying conditions. She must, on short notice, become an integral part of a complex organization. If it happens to be in the hospital maintaining the school of nursing from which she graduated she will find it relatively easy to adjust herself because she will already be familiar with technic, procedures and regulations which prevail. However, there may not be sufficient demand for her services in her own hospital at all times. Hence, if she wishes to work it may be necessary to take home cases or care for patients in other hospitals. In the latter event she will usually find it somewhat difficult to adjust herself to an organization which in various respects may function differently from that with which she has been familiar. This is particularly true on the occasion of her first assignment to a foreign hospital.

Since the duration of cases is uncertain, varying from one day to weeks or months, there is a possibility of being called to serve in several hospitals in a comparatively short time. Naturally, a nurse finds it difficult to cope with such a condition. For the capable and conscientious nurse who gives a good account of herself this should not be of frequent occurrence and I think that the hospital and registry can to some extent control this situation, if the nurse will apprise them of the fact that she is getting more than her share of short cases.

The hospital management must realize the importance of its private duty group and give due consideration to the problems involved, in order

that these nurses may be able to carry on their duties as efficiently and smoothly as possible. There are certain things which the hospital must provide and do.

Likewise, certain requirements are expected of the nurses as individuals and as a group. The nearer we can come to understanding each other's problems, which are largely mutual, the better the patient will be cared for. And, after all, it is solely because of patients that nurses, doctors, and hospitals exist. That there is often a lack of appreciation of each other's difficulties I think is self-evident, because we often hear the remark made by hospital executives that private nurses are a constant source of trouble. On the other hand, individual nurses are apt to express their poor opinion of a hospital in no uncertain terms.

Recently, in conversation with a Lutheran clergyman who has been in the active ministry for more than forty years, he said that in the early years of his career his contacts with the children of his congregations had not been as satisfactory as they should have been. He seldom had any difficulty in teaching and managing the girls, but with the boys the opposite was true. In looking backward, he felt the fault was largely with himself, because as a youth and young man the general community attitude, toward boys in particular, was portrayed in the proverb, "Spare the rod and spoil the child." In other words, while it was possible to manage girls with kindness and persuasion, the boys had to be handled with different tactics; namely by instilling fear and exerting arbitrary authority. As years have gone by, he has come to a better understanding of boys and their problems, with the result that one of his greatest joys and satisfactions has been in working with and for the boys.

Similarly, I am inclined to think that at least some of the differences which have been experienced by hospitals with private duty nurses have been due to a lack of interest in and understanding of their problems. That there has also been a lack of appreciation of the hospital's position by some nurses is unquestionably true.

It might be well to give a little consideration to the difference in relationship of the hospital to the student nurse and to the same nurse after she has graduated. It is self-evident that definite changes have taken place and that our aims and interests, though centered in service to the patient, are not quite the same toward each other as they were.

The student nurse is a dependent being and, because of her appreciation of the fact that she is not wholly competent, she is more amenable to rules and regulations, more open to suggestions and criticism. She is anxious to learn and, because of her aim to eventually graduate, she tries to measure up to all requirements. As she becomes more and more familiar with her duties and responsibilities, she feels herself to be an important part of the hospital organization. Furthermore, she becomes imbued with the *esprit de corps* so necessary in every type of organized effort. Her economic welfare is the responsibility of the hospital to a large extent. She is there to learn through theoretical and practical instruction, and the hospital provides such instruction, living accommodations, meals, laundry, and other necessities. In return she performs her duties to the best of her ability and strives to acquire a good classroom record.

Upon graduating, she is suddenly thrown upon her own resources and is no longer a regular part of the organization. She becomes a free agent

and realizes that she must look after her own interests. Her aims and ideals, with respect to her high calling of being of service to the sick, are as lofty as ever, but they are somewhat tempered by the necessity of earning a livelihood. The nature of her work has changed, in that she must satisfy only one patient at a time. Employment is uncertain because there will be periods of much work and other times of enforced idleness. In the degree that she can please her patient she will gradually build up a clientele, thereby receiving assurance of a more constant demand for her services.

In her eagerness to please, however, she is apt to lose sight of the necessity of the hospital to give adequate care to all of its patients, whether on private or general duty. In achieving her immediate ends she may not be as considerate as formerly of her fellow nurses in the private or general duty group. She is intensely interested in the welfare of her patient and, though she may not mean to disregard the rights of others, her general attitude indicates a rather jealous desire to secure all prerogatives and as many special privileges as possible. She has not forgotten what she learned during student days regarding economical and proper use of supplies and equipment but, instead of being as conscientious in this respect, she has a tendency to disregard what was taught her and feel that since her patient is paying for hospital and nursing service he is entitled to everything she can get for him. Occasionally we hear the remark that, at prevailing rates charged for private rooms, it would seem that the hospitals are making such a huge profit that this, that, or the other thing should be provided without question. But when we consider that this, that, or the other thing may be as varied in number and character as there are different patients or nurses, it is plain that there must be a definite control over the amount of leeway given. It is certain that, without restrictions on the part of the hospital management, costs would be vastly increased over their present level. There is no reason why the patient occupying private accommodations should not pay a profit to the hospital, nor why this margin should be reduced by unnecessary expense due to carelessness or unusual demands. I cannot help feeling that it is as much of a privilege for the private-room patient to have access to the facilities of a general hospital as it is for the patient paying less than cost or nothing. The well-to-do suffer from the same diseases as do the poor, and even the extremely rich would not deem it economy nor wisdom to build hospitals for their own particular and individual needs.

In saying these things I do not want to go on record as having indicted the private duty group as a whole, but merely to mention some of the tendencies of individual nurses after they graduate, and to point out the necessity for them to appreciate the responsibilities of the hospital.

It must be admitted that the hospital on its part does not have quite the same paternalistic interest in the graduate nurse that it had when she was a student, but it is still interested in her welfare. Pride is taken in the success of each individual nurse and assistance is given her in securing institutional or other positions whenever their records justify such help. In so far as private duty is concerned, the hospital makes every effort to use its own graduates first before calling nurses from other schools, not only because its own graduates should be best qualified for work in their hospital but also because

of a sense of loyalty on the part of the hospital to its alumnae.

The hospital is principally interested in the welfare of the patient and it follows that, to achieve this end, it must also be interested in every group and individual serving in any capacity. The nurses are of the highest type of hospital worker and have the most intimate contacts with the patient population. Therefore, as hospital executives, we are extremely interested in their well-being.

In order that the nurses may function as efficiently and comfortably as possible, the hospital must provide whatever is reasonably needed. Dressing rooms and lockers are a necessity. As to size and appointments they will vary in proportion to the size of the hospital and of the private duty corps. The ideal is to have these facilities on each floor but, where this cannot be done, the most conveniently located arrangement should be worked out. Lockers should have keys. Various schemes have been tried to assure prompt return of locker keys when the nurse finishes her duty with a given case. One method which should work is to have the nurse make a deposit when she receives the key. But there are always some nurses who will not coöperate in this or any similar system, with the result that before long a considerable number of keys are unaccounted for and duplicates must be procured. This is most undesirable.

The nurse is entitled to good food, well prepared and served. It should be adequate in quantity and variety to meet her reasonable needs. However, at the prevailing prices of $1 to $1.50 per day for nurses' board, it cannot be superlative in any respect. I suppose every hospital experiences more or less difficulty in its routine feeding, whether it be patients, nurses, or other groups. Economically no hospital can give an à la carte service and, even though it were possible, there would still be some dissatisfaction. Those institutions that have inaugurated cafeteria service seem to come nearest to the ideal in this respect.

When the nurse reports for duty, she should be met with cordial dignity and, if it is her first duty in the hospital, should be given special consideration by the individual who receives her. No doubt it would be well for hospitals to have printed rules and regulations briefly setting forth their requirements and giving such information as will enable the nurse to orient herself in her new surroundings as quickly as possible. The various hospitals securing nurses from a central registry might find it advantageous to work out uniform general rules which would apply in each institution. This would help both nurses and hospitals. It is expected that a nurse will conform to these general rules and that she will coöperate in every possible way.

She should be careful in the use and care of equipment and also exercise economy in requisitioning supplies, linen, and foods. What the patient needs she has a right to expect but, for instance, to order special dishes for her patient simply to be sure that he will receive his money's worth, or because a patient in a neighboring room has ordered something of similar nature, is not a sensible nor a loyal attitude. The nurse should have certain equipment of her own, such as thermometers and hypodermic syringe. Other supplies and equipment should come from a conveniently located station.

Idle gossiping with regard to each other's patients, unjust criticism of the hospital, the doctors or the personnel, is at all times in extremely bad

taste and reacts upon the nurse. It is especially harmful if such conversation is carried on in the hearing of student nurses or patients. When she has a just grievance, it should be taken up with the floor supervisor and, if this does not bring results, she has access to the nursing office.

The supervisor and charge nurses should willingly coöperate by rendering assistance promptly as needed. They should keep in close contact with the special nurse and her patient, offering advice and suggestions when, in their judgment, they are called for. Granting of special favors to either patient or nurse will depend upon the rights of other patients and nurses on the floor. Most difficulties can be adjusted without undue commotion, but there will be times when a decision must be arbitrary because, with so many individuals with different likes and dislikes, it is impossible for any hospital to give 100 per cent satisfaction.

Every hospital has, or should have, a committee on nursing and it may be well to refer matters of policy involving radical changes to it for approval. However, periodic conferences with the superintendent of nurses will usually make for harmony and agreement.

In the hospital which I represent we are able to take care of our private duty requirements from the ranks of our own graduates, at least to a great extent. Our experience has been that, aside from a lack of familiarity with certain routine procedures, graduates from other hospitals have little difficulty in carrying on. More often difficulties are experienced with graduates from our own school. This is largely an individual matter and, when this is not true, there must be some underlying cause which may be the fault of the hospital and should be remedied.

I have tried to set forth frankly some of the requirements of both the hospital and the nurses which will ensure good relations.

In conclusion, a hospital, like a home, does not fulfill its purpose simply because people work or live there or because it has a suitable building with fine equipment or furnishings. There must be a spirit of helpfulness and respect for the rights of one another, with a desire on the part of each one to contribute something for the good of the whole. This spirit will make a real hospital as well as a home.

The private duty nurse is a splendid type of individual with high ideals and she is anxious to please her patient by giving conscientious service. If at the same time she is loyal to the hospital organization she happens to be working with, and if the hospital on its part coöperates in every reasonable way, there should be no real problem that cannot be solved. That there should be differences of opinion is only natural but with due respect for the authority of the hospital and an appreciation of the fact that rules and regulations are a necessary part of the mass care of the sick, and that the private duty nurse needs the hospital as much as the hospital needs her, we should be able to carry out our mutual aim of service to the patients without undue difficulty.

Hospital Relationships from the Private Duty Angle[1]

FRANCES M. HEINRICH, R.N.

WHEN I was asked to present a paper on this subject I did not realize what a peculiarly difficult task had been allotted me. Perhaps you wonder why I make this statement, for it may seem a simple matter to present this subject, but I feel sure you will all agree with me that there are many angles and that, in approaching each one, I must be fair to both sides, with a frank, unbiased, and open mind.

First of all, I feel that to have a perfect understanding and happy relationship between the hospital and the private duty nurse, each must be able to understand the problems of the other, and in order to gain contentment for the patient, who is after all the center, there must be perfect cooperation of those who have his welfare in hand.

In order to cover this subject briefly, I feel it best to divide it into two parts: the first that of the hospital, the second that of the nurse.

From the hospital angle I shall start with the office of the superintendent of nurses and divide this into component parts for closer consideration.

The Hospital Angle

HAVING reached the office of the superintendent of nurses, let us note how the nurse reporting for duty is received, what instructions are given her as to rules and regulations of that particular hospital.

1. If she be a newcomer, she should be handed a printed list of rules.

2. Someone should be ready to direct the nurse to the patient, so that she does not lose valuable time or become embarrassed by wandering aimlessly about.

3. Adjustment of any difficulties which may be incurred by the nurse should be through the office of the superintendent of nurses if proper adjustment is not made through the floor supervisor.

4. Adjustment of complaints of patients, such as lack of courtesy or attention by any hospital employe.

5. Investigation and adjustment of inability the nurse may have in obtaining necessary supplies from the service, linen rooms or diet kitchen, if no satisfaction can be had from the floor supervisor.

6. Proper assignment of cases, with fairness to the patient as well as to the nurse.

7. Investigation of repeated refusal by nurses for certain types or location of patients.

8. Proper dressing-room facilities, with adequate locker space, keys for same, room to be well ventilated and lighted and not overcrowded.

9. Should a hospital feel privileged to register against certain nurses, those nurses should be given the benefit of a hearing before a representative committee made up of a member of the private duty section of the district association conducting the registry, a member of the hospital staff, a member of the alumnae of the hospital, and a member of the alumnae to which the nurse belongs.

10. The hospital should be privileged to deal with a nurse who is spreading malicious gossip or criticism or who is not living up to the ethics and traditions of the profession.

11. If a certain nurse is desired by a patient, that nurse should be given the opportunity of accepting the call, regardless of her place on the registry, or whether she be a graduate of that hospital; if she happens to be on a case at the time she is requested, she should be given the privilege of talking with the patient, so that the patient may understand why she cannot serve her.

12. Is it fair, when a patient can afford and is willing to retain a nurse, for the doctor to discharge that nurse? This happens fairly often. It is a delicate professional point and it would be interesting to study it and see what could be done in a tactful way. Has anyone any suggestions?

[1] Read at Registry Round Table No. 1, Biennial Convention, Milwaukee, Wis., June 12, 1930.

13. The attitude of the floor supervisor and the students should be courteous, fair, firm and coöperative. As special nurses in most hospitals must give detailed written daily reports of their patients, is it necessary that the floor supervisor make frequent or infrequent calls to that patient's room? Would it not be better for that supervisor to take that time in following up more closely the work of the student nurse in regard to the care of the general duty patient and ward routine? It should, however, be the duty of the floor supervisor to enforce the following:

(a) Quiet in corridors, rooms, and at chart desk,
(b) Conservation of hospital supplies,
(c) Neatness in appearance of nurse,
(d) Tact in discussing conduct or management of staff with the student body.

14. Nurses' meals. A well balanced diet with pleasant surroundings and dining-room service is every nurse's privilege and right. The night force, for example, too often is shown lack of consideration to needs and manner of service. Also, nurses having to follow special diets should, upon recommendation of their physician, be accorded the privilege of being served such a diet through the diet kitchen.

This, I think, about covers the hospital angle; let me now proceed to the nurse's angle.

The Nurse's Angle

1. How does she introduce herself; what is her appearance and general attitude?

2. How does she accept instructions given her?

3. If difficulties arise, how does she face them? Does she bluster or scold, or does she tactfully try to reason them out before making it necessary to take the matter to the office of the superintendent of nurses?

4. When patients complain of dissatisfaction, what does the nurse do? Is she loyal to the hospital and the physician in charge, yet withal appeasing the patient and gaining a satisfactory adjustment?

5. If she has difficulty in securing necessary supplies, does she try to coöperate with the hospital in always being careful in her use of and demand for supplies? Is she not justified in trying to secure for her patient that which is necessary for his comfort and wellbeing?

6. Are nurses always fair in the matter of accepting or rejecting calls, or retaining the same?

7. In the matter of dressing-room facilities, is she considerate of the rights of others, does she coöperate in trying to maintain order and neatness? If so, she is entitled to comfort, convenience and consideration. Here I would suggest that on each floor, preferably in the dressing-room, there be a cot, so that the special nurse might relax for a few moments during the long, twelve-hour day.

8. If the hospital fails to call a nurse for special request, is it not that nurse's privilege to ascertain why she has not been called?

9. Nurses cannot be too careful in listening to or spreading malicious criticism or gossip, and the method of avoiding this pitfall is to concern ourselves only with our own affairs. It is, of course, a great temptation to talk over our problems and also those of others, but it is very dangerous, and generally leads nowhere. One must have an open mind and be able to place herself in the position of others. However, I do feel that one must have the courage of conviction, and I do believe that conditions can be corrected or adjusted if properly approached. And how better than by taking them to our private duty section meetings? Above all else, we as a group should be most careful not to discuss hospital routine or management with the student body.

10. The nurse's attitude toward supervisors. If she expects courtesy, fairness, coöperation and consideration, she must herself observe these niceties. However, if she feels she does not get what she needs for her patient, or the coöperation she deserves, she is justified in taking her problem to the proper authority, the office of the superintendent of nurses.

Summary

TO summarize, I have tried to cover many points, but feel sure there are many I have overlooked. It seems to me that the crux of the situation lies in this: first, the broader our outlook on life, the better we can appreciate the problems of those about us; second, we must take into consideration the fact that we all tend to become specialists and therefore are apt to be narrow or biased in our views. The greater experience we have in nursing, and in the amenities of life, as well, the better results we can obtain and the happier we can make our relationships, not only with

our patients but with those with whom our work is so closely allied. In my opinion, there is too little stress laid upon the importance of the nurse's need for a broader experience after graduation, for specialization tends to absorption and makes one forget how to play and enjoy life as well as work.

Each branch of nursing is an education in itself; therefore the nurse who changes her line of work at different periods of her career, taking, for example, a few years of institutional work, public health, social service with postgraduate courses, additional schooling and private duty, must have a better understanding of the individual situation and be a more useful member of the profession. An interest in music, art, literature, domestic economy, dancing and other social recreations, should be included in a well-rounded experience. However, it would be difficult to take any active part in these activities with the present working schedule of the private duty nurse. For instance, for those doing twelve-hour duty, there is very little time left for outside interests after the long twelve-hour stretch, and the twenty-hour duty nurse is worse off, if anything. Nurses must get together on this. It is not asking too much to work for a ten-hour day.

I feel that any superintendent of nurses should have had some contact or direct experience in several of the other branches of nursing, especially a bit of private duty, for only then can she, and through her, her staff of workers, be able to appreciate the problems confronting the private duty nurses. I feel, too, that every private duty nurse, at some time during her career, should have had experience other than private duty nursing, thus making the relationship of the hospital with the private duty nurse clearer and happier.

Long before the Official Registries

A DIRECTORY for Nurses in Philadelphia was formally opened on May 15, 1882. The acknowledged success of the work has been due to the following facts:

(1) The directory is conducted under the management of the College of Physicians, an eminent body of regulars, who undertake nothing that is in any way opposed to true medical science; (2) the great care manifested in obtaining nurses, each applicant being subjected to the most comprehensive questioning; (3) the devotion of the nurses to their work.

Taking up more closely the second of these causes, let us see how carefully the rights of the community are guarded against ignorant or unworthy applicants. In the first place, graduates of recognized training schools are registered on presenting their diplomas, without further references. To all others blank forms are given requiring a statement of the name, age, address, qualifications, kind of nursing preferred, rates of charge, and both family and medical references. References to three physicians must be given, together with the names and addresses of three families in which the applicant has nursed during the past two years. Confidential blanks are then sent to each of the three physicians referred to, asking for information concerning the applicant's character and qualifications.

The confidential blanks to the families where the applicant has nursed are equally searching in their questions. If the replies from the references are satisfactory the nurse is registered after the payment of a fee of three dollars. The supervising care exercised by the management does not stop here, however; for, after every engagement, detailed inquiries are sent to both the physician and the family, in order to learn more and more of the nurse's qualifications.

The Directory reserves the right to drop any name from the register if grave faults or defects are proved against the person.

This registry had also wet nurses, nongraduates, manipulators, cuppers and leechers.

Trained nurses are in demand and many more are needed. The Directory is not only for those who want the highest priced nurses; the wants of all are provided for. Many of the nurses charged only from five to eight dollars a week. The rates are fixed by the nurses themselves. All that the Directory does in this regard is to register the rates, and to see that nurses do not charge beyond the stipulated sum.—From the *British Medical Journal*, Sept. 1, 1883.

Registry Relationships[1]

From the Angle of the Registry Executive

MARY MARGARET MUCKLEY, R.N.

TO MEET the community's need for nursing care, to create a central headquarters for nurses and nursing interests, to maintain a high standard for professional work and ethical conduct for its members; these are listed as reasons why nursing associations operate and maintain an official registry. The putting of these objects into motion create the registrar's problems. The problems of a registry are many and some may seem too small to mention, but in dealing with several hundred human personalities, each having tastes and desires a bit different from the other, a number of difficulties appear for adjustment.

Time does not permit a complete listing of problems, and so a few of the more troublesome ones have been selected because of their far-reaching effects.

The registrar has to deal with four groups of persons:

1. The nurses who make up the registry membership.
2. The hospitals to which the registry members go when private duty care is needed.
3. The physicians and surgeons who call private duty nurses to care for their patients.
4. The general public to whom care is given and who pays the bills.

To have the registry program run smoothly, each group must be pleased to a certain degree, and this must be done without upsetting the ideals of the nursing profession or the policy of the registry organization.

Nurses, of course, have the greatest interest in the registry. It gives them their professional backing. It is the one central point through which their professional aims and progress go on, and yet they do some funny things. They forget that sickness is no respecter of persons, times or places. They refuse to take certain cases, or to go to certain places to care for patients. This sometimes nullifies "that the registry was organized to give skilled nursing care to patients in its community." All patients cannot or will not go to the hospital and have special nursing care, too. So they often choose what seems to them the lesser evil—the care of a practical nurse in the home—and many registered nurses wonder why home work is falling off. It is impossible for any registrar to develop or keep up calls for nurses in homes if she has no one to take such cases.

Registry members seem to depend so much on "What's my number?", little realizing that personality, ability to adjust oneself, age, professional background and often nationality are listed first when a call is placed for a private duty nurse. We have for some time been trying to bring this home to our members but we are far from complete success. The professional background of the nurse gives the registry executive less concern than does personality. "She is a good nurse but—" or "She gave good nursing care to the patient but she did not fit in" are said so often about nurses. Since the vast majority of nurses in any community are doing private duty nursing, it is no small piece of work to equalize the calls and have every patient feel that his nurse fits in beyond criticism. Selecting a

[1] Read at Registry Round Table No. 1, Biennial Convention, Milwaukee, Wis., June 12, 1930.

nurse who will do best with the especial case for which she is called, is of course the ideal way, but such is not often the privilege of the registrar. When a certain nurse is asked for, she is sent, regardless of whether she is number one or fifty, and if a stated nurse is not asked for, the registrar is bound by rules to send the first nurse who is not registered against the type of case for which a nurse is being called. The members of our official registries meet the minimum requirements as to professional rating and yet many are inelastic in adjusting themselves, and so arhythmic in personality; but they have the necessary credentials, they pay their dues, and so it becomes the registrar's task to see what can be done to make them succeed.

The registry membership has been and will always be just what the nursing schools graduate. The registrar must often wonder just why some nurses were permitted to finish their training, especially when there is difficulty in getting the superintendent of nurses to give frank statements of their work as students. Nursing schools graduate students whom they will not call back on cases. Many vital reasons are given, and yet it is expected that the registry executive will take the responsibility of sending them on cases in homes or other hospitals. Often these nurses do well in some other line of nursing if the registry executive can interest them to prepare for and to enter some other nursing branch. Too often, however, they fall back on the registry again, and the complaint comes in once more: "Why did her school graduate her?" The nurse is going into the home or the hospital to care for the sick and she is the representative of the registry in every instance. Can we afford to continue taking on members who are not pleasing to family or patient? Should we carry these members, knowing that when we send them on cases, in twenty-four or forty-eight hours they will be back on call and the registry will be asked to send another nurse, "not her type." Are we doing justice to patients and nurses in general?

What the registrar should do for the graduate of years ago often causes no little concern. She is a woman well trained, of good personality, industrious, willing to take cases anywhere, but patients and physicians prefer the younger woman. When calling for a nurse they will often state approximately what age they would like the nurse to be, and when specifications are not made, and the older nurse is sent, she may be embarrassed by being told she is "too old to take care of this patient"; yet she is not disabled, and she gives good nursing care from every angle, but because she has advanced beyond a certain age, she is termed "too old." Even though she has done private duty nursing during her entire career, this older nurse is often the one who has given time and service unlimited in the organizing of the nurses' association and in the advancement of the nursing profession and it does seem that some consideration is due her.

The registry members can be the best publicity agents. The way in which they execute their work, fit into situations, collect their fees, coöperate with the physician and the hospital, their attitude toward problems which arise in connection with their work, will all be to the advantage or disadvantage of the whole registry membership; for all nurses will be judged by what one did, since she may be the only one whom that patient knows.

In dealing with hospitals, the problems are different. The registry is often the only link between the

private duty nurses and the hospitals, and it is given blame for much over which it has no control. If nurses do not wish to take certain hours or certain cases, hospital executives often feel that the registry should force them to do so. It is true that registering against hours and cases reduces the amount of work the nurses may have, but on the other hand, why force any one to do that which makes her unhappy? Sometimes nurses are called when so little information regarding the case is given that almost high pressure salesmanship must be used to secure a nurse. Nurses cannot be blamed for resenting this, for in very few instances is it impossible for the hospital to be able to give some idea as to the nature of the case. If the nurse can be given even a wee bit of such information, she will know what to expect and she will make a better approach to the patient. If hospitals do not call their nurses according to number, or if a nurse is called for the hours or cases she registers against, and the like, it is so easy to put the blame on the registry. A common understanding between the hospital, the nurse, and the registry does away with practically all such difficulties. Hospital executives and registry members alike have a very faint idea of how a registry is operated, and were both parties to take the time to visit the registry office, to observe how this work is done, a difficult problem could very soon be eliminated.

With the medical profession, the problems are different. Many members of this group know little or nothing about registry conduct and just as little about nursing. Many do not consider the nurse a co-worker, nor do they understand what the nursing profession stands for; some do not know the difference between a registered nurse and a practical nurse, and so the fun of straightening out troubles and misunderstandings goes on.

If the three groups already mentioned—nurses, hospitals and physicians—understand to some degree the aims and policies of the organization which maintains and operates the registry, the fourth group, the public, will quickly be a staunch supporter. For what the public wants is good, skilled nursing care, and it will ask for such service when it knows that it is available and where it can be secured.

The registry has for its membership private duty nurses and is, therefore, concerned first with the needs, life and aims of this group, which makes up about three-fourths of the membership of any local nurses' society. The private duty nursing group make contact with more persons in any given community than do nurses in any other branches of the work. Those outside the profession know nurses first through the private duty nurse. It would, therefore, seem not to be amiss to have a lay advisory committee to the registry, with whom and through whom much healthy and sound public education could be done. This committee, a picked one to begin with, and having on it both men and women to represent the hospital council, medical, and dental professions, persons in business and the educational field, could do a great deal of word-of-mouth publicity in selling registered nurses' services. Objections are often raised, when mentioning such a committee, because nurses feel that it would want to dictate all the policies of the organization. No doubt some members of a lay group would enjoy doing so, but that can be controlled. Lay people have helped markedly in the cause of public health, through the many national, state, and local societies, and I see no reason why they

should not be given a chance to help the cause of the private duty nurse through her registry.

Registries are gradually but surely taking a definite place in the community, and in doing so success can be reached only by having a sympathetic understanding from persons outside the profession, who are educated to understand, and, knowing the aims and desires of the nursing group, will lend their assistance. Registries have existed for some time but only recently has their importance been recognized. The registry office forms a logical headquarters for the association members and the demands made upon it are constantly growing. The executive in charge is an important person, as such, and if she fulfills her duties well, she will realize her responsibility in seeing that the nursing needs of the community are met. It may be that the program which a registry has been carrying on no longer suffices. The change in conditions may call for a change in registry work. It is a huge problem at times to swing this and to win over the committee in charge of the registry operations and the board of directors of the association. The registry cannot think only of hours and fees for the registered nurse, her life and aims; it must also consider what the community needs and do its best to meet this need. Practical nurses fill a certain need, and they are here to stay. Making it possible for a good grade of practical nurse to register at our official registries and controlling the fee she may charge and the types of cases she can handle, and supervising her work would be a big step toward meeting the community needs. Hourly nursing too may be a service the community would appreciate. I know many nurses believe that hourly nursing should be a part of visiting nursing, but I have not in mind the work of teaching and supervising, but rather the home where the patient needs, wants and can afford to pay for one or two hours of skilled nursing care per day, at a rate per hour which covers the entire cost. To such needs as these just mentioned the registrar must give thought and study. Requests for varied nursing services come to her, but it is not always easy to get the committee in charge to see the necessity for making provision to meet them.

The problem of the utilization and distribution of private duty nurses demands serious consideration. "We graduate too many nurses" is a cry heard so much now. In looking over the situation in smaller cities, one is prompted to say "coagulation, not over-production." To interest nurses in locating in smaller cities and surrounding themselves with a clientele either in private duty or in hourly nursing would be a means for patients to have better nursing care, and nurses engaged in nursing to have more work. I can feel someone thinking that that can't be done. But until a nurse gives this a trial she can scarcely say that it will fail. Repeated refusal to go out of the city on cases, has turned the attention of patient and physician toward the practical nurse. It is very difficult for a person to be in favor of skilled trained nurses when he has so little opportunity to make comparison. We have a member in our association who located in a town of 4,000 population about forty miles from Minneapolis. She is doing private duty, receiving the same fees, working the same hours, that the nurses do in the city and she is not wanting for work. When the spirit moves her, between cases, she comes to the city and shops, sees plays, and goes to places she is interested in. She

says she is saving money and enjoying her work. But she is doing something much greater than that. She is making it possible for patients and doctors in that little town to know what good, reliable and intelligent nursing care is, and what it can mean to the patient and his family.

The registrar's problems are increased or decreased according to the association's program of public education in regard to private duty nursing. Because private duty nursing is older than some of the other nursing branches and because private duty nurses meet many families during the year, not enough attention is given to the fact that, in spite of this, the public does not know enough about the registry. Articles in periodicals which are read by local persons do not suffice; nurses, not having been trained as advertisers, can give little publicity help. Public education is two-thirds of any game, and must receive thought and attention if any amount of success is to be hoped for. Opportunities for public education must be grasped as they present themselves, and opportunities must be made to send out the message of the value of a trained nurse by mouth or print. This must be done with tact and diplomacy. We have stayed away from publicity so long that great care must be exercised in putting our value before the public. We cannot give publicity to the individual private duty nurse because her work is such intimate, personal service. Therefore, the organization of which she is a member must be used as the unit for publicity. The usual advertising card in magazines and the like, which many registries use, has little or no value; it does not seem to reach the right persons. Too much of such publicity is being done and it falls by the wayside because a nurses' registry advertisement looks like any other, and when some ten or twenty advertisements are crowded on a page, it merely resembles a patch in the printer's crazy quilt.

Since the care of the sick is the nurse's task, and sickness may visit any home, those who are prospective patients must be taken into our friendship and permitted to know us as we really are, and through knowing us, they will be workers in carrying on a program of public education.

By the time the problems that I have mentioned are solved, new ones will be sprouting. Each new development brings its difficulties. Changing conditions make new demands and this indicates life and growth. The nursing profession possesses both. Signs on the horizon foretell that in the future as in the past the nurses will meet the situations as they come, and do it satisfactorily. I am sure that at such gatherings as this, much helpful information can be gleaned, which when taken home and put to use will tend to lighten the registry's burdens.

The Relationship of the Registry and the Private Duty Nurse[1]

LENA M. SCHMITT, R.N.

THERE seems to be a very urgent need of a better understanding of what the job of the registrar involves in her relationship to the registrant; and what the relations should be between the registrar and the private duty nurse enrolled on the registry. It is only by a study of the needs of the registrar, on the one hand, and the registrant on the other that we may learn the best interrelations to promote closer collaboration, and to find if possible practical methods for coöperation in order to meet the needs of patients and at the same time equalize the burdens and privileges of both the registrar and the nurse.

The registry is primarily a medium through which the public may be supplied with nursing service, and secondarily a medium through which the nurse may receive calls to render this service.

The obligations of the registry and the nurse are reciprocal. This reciprocal relationship holds as truly between the private duty nurse and the registry as in any other "give and take" relationship. Many nurses look upon the registry as a place of convenience, while the registry looks upon the nurse as a medium through which the business of the registry may be carried out most efficiently. In many cases neither the registry nor the nurse recognize their mutual responsibilities.

The obligation of the registry is to supply calls to the nurse in a fair, impartial manner. The obligation of the nurse is to be ready, after she registers, to receive and execute these calls promptly and efficiently.

To better understand why the private duty nurse fails to fulfill her obligations to the registry, let us consider her reasons for selecting the private duty field under the following headings—economic, professional, and social.

Nursing is an idealistic profession, but that does not necessarily render it immune from economic consideration. The advantage of a fairly high daily wage with board included may appeal to the young graduate. In her mind she figures she will have a greater remuneration than in another branch of nursing, where the daily compensation is less than in the private duty field. This shows lack of sound economic training, as income computations must be made on an actual earned, yearly, basis. The nurse often starts out with this idea of high wages in mind, gets caught in the mesh of private duty routine, and follows the line of least resistance, staying in the private duty field.

Our study of the report of the Grading Committee has shown us that:

> The amount of money the typical private duty nurse earns is pitifully small, and in addition the nurse works under the serious handicap of never knowing from day to day what her income will be. Private duty nurses live from hand to mouth. This system is hard.
>
> The income of private duty nurses is, however, definitely less than that for nurses in either the institutional or public health fields. While there are some high earnings, half the nurses in private duty earn less than $1,300 a year. Some earn only $400 or $500 a year and are living on savings or gifts from relatives.

Professionally, the nurse's reason may be that she enters the private

[1] Read at the Registry Round Table, Milwaukee, June 12, 1930.

duty field in order that she may have an opportunity to develop along one special line; *e. g.*, obstetrical, pediatric, or psychiatric nursing. She may wish to work with a group of specialists, or an individual specialist. It may be from a desire to render complete service to the patient, giving full satisfaction to the patient as well as to herself. Nurses working in hospitals or under a visiting nurse plan, do so under more or less pressure with the time element very definitely before them, while the private duty nurse who is interested primarily in giving complete service, is free from the burden of this pressure, and can develop her technical skill to an unlimited degree in caring for one patient. One registry says:

> We should like to feel that her motive is to take care of only one patient, but we have been made to realize that it is more the lure of the free lance work method, where she is not allied to any institution. Those who understand the system best and have studied it closely think this probably is the rock upon which the private duty nurse will founder.

From the social standpoint she may enter private duty with the feeling that she is marking time until marriage will release her from the responsibility of self-maintenance. Therefore she takes neither herself nor her profession seriously. However, marriage does not always relieve the nurse of economic responsibilities.

The nurse in order to satisfy these professional, economic, and social demands allies herself with a registry. What may the nurse expect from the registry? The relationship of the registry to the private duty nurse must be a coöperative one in order to completely fulfill the purpose of their interalliance.

If the registry states it is established to give nursing service to the community, coöperative plans should be mentioned. It is not coöperative unless the private duty nurse will keep in close touch with the registry. If there is any question in her mind as to whether she has been given fair treatment, for instance, she should understand the system of placing calls. There should be frequent meetings of registry and private duty nurse, as no coöperative enterprise can exist without frequent meetings for consultation and advice from both parties concerned. As to the method of assignment, it has become a rather fixed system in the official registries to list nurses as they register. This is not coöperative, because a nurse is not always sent on suitable cases, thus adversely affecting both nurse and community.

Registries have found it necessary to make some night duty compulsory. In the registry where the speaker registers, the first agreement the nurse must accept is that nurses accept the use of the registry with the understanding that they take day or night, hospital, or outside calls.

Night Duty.—It has been found necessary to make this ruling in order to fill night calls. Looking at it from the standpoint of the private duty nurse, who lives in the city where quiet sleeping quarters are at a premium, night duty becomes a very great hardship. If she does not get enough rest to compensate her for twelve hours' duty at night, it is evidently an abnormal arrangement. The constant readjustment between day and night duty is very trying, and it ultimately becomes a question of health. Hospitals often fail to provide relief for night nurses. The question here arises, Has the registry any responsibility in bringing pressure to bear to create more acceptable conditions for the private duty nurse? If night duty is to be compulsory, the

conditions of night duty must be improved.

Out-of-Town Calls.—The nurse is reluctant to go out of town on a case because this usually means 20-hour duty, which is in fact 24-hour duty if the patient is very ill. Usually the private duty nurse likes bedside nursing, but does not enjoy going on cases where she feels she is wasting time. Invariably, the nurse likes taking care of really sick patients, but does resent being compelled to spend hours and hours, listening until bored to death to tales of illness or family troubles, with persons with disagreeable personalities or worse, or with the pampered wealthy people who can buy everything but health.

In the case of the very sick patient she gets very little or no rest at all for an indefinite length of time. In the other case she feels it wasted time, which she cannot afford to give.

Home cases call for different technics from the hospital technic. The nurse must improvise and this is sometimes difficult for one who is not trained in home technic.

Staying in for Calls.—The registry does not require the registrant to have her name always on call, but it requires her to be ready for duty when she does register.

The Detroit District requires that the registrant who is on call must not be out of reach of the Registry for more than an hour at a time, without first notifying the registrar of the fact.

During long periods of unemployment when the nurse feels she must keep her name on call so not to lose her place, it becomes a very great strain on the nerves to sit at home ever listening for the telephone to ring. She is afraid to leave the house for fear of missing a call. This does not leave the private duty nurse very much time for relaxation and freedom from worry, or time to devote to interests outside her profession.

At these times the economic element enters in also. Her expenses are going on, she must live, sometimes even the price of telephone calls is an important item to her.

This whole condition seems to reflect upon one of the three great handicaps of the private duty nurse, as found by the Grading Committee, namely:

(1) The overproduction of nurses. This results in unemployment problems which are especially acute in the private duty field, since the field must absorb all workers who cannot secure either public health or institutional positions.

Has the registry any responsibility in trying to correct these conditions? It is important that people who come together to discuss this question, arrive at some conclusion as to whether or not the registry has responsibility in bringing about corrections to make it more of a coöperative plan.

Though we hear plans discussed to supplant the private duty nurse, it has not been proved that we can get along without her. So we must make conditions suitable for her to continue.

(2) The second handicap is that "Private duty is a free lance occupation open to all comers. Good nurses suffer from the competition of women far below their level in breeding and intelligence, professional ethics, and nursing knowledge and skill."

(3) The third is "The free lance worker in nursing, as in other professions, inevitably pays for her cherished independence of action through lowered income, irregular employment, and extreme professional loneliness."

However, we do know that there are extenuating circumstances to exonerate the private duty nurse when many criticisms are made of her.

In order to develop closer coöperation and mutual respect between the registry and the nurse, the registrant should avail herself of every opportunity of obtaining first-hand information concerning demands of the community for nursing service and the means whereby these demands are satisfied. No doubt one day spent at Registry Headquarters would be very revealing. With this background, the registrant would probably be in more sympathetic touch with the problems of the registrar. She would feel herself a part of the whole organization and not just an individual whose varied likes and dislikes must be satisfied at any cost. She would have probably a more tolerant attitude toward the assignment of cases.

This close contact would probably give the registrar a keener insight into the personality and potentialities of the registrant. It would probably awaken in the registrar a more tolerant sympathetic attitude toward the problems of the registrant and would quicken in her a desire to be of greater service and help in placing the registrant in situations which she is best suited to meet.

The following recommendations are offered as possible aids in the solution of some phases of our problems:

1. Some plan of grading private duty nurses and then assignment of duty according to merit.
2. Opportunity for growth, afforded by compulsory attendance at at least 75 per cent of Section meetings for two years after joining the registry.
3. Constructive leadership which would be developed as the nurse grows in group consciousness from attending the Section meetings.
4. Some plan by which the registrant and the registry meet at stated intervals to discuss their mutual problems.

In closing, may I say to the private duty nurse—

But how can she expect that others should
Build for her, sow for her, and at her call
Love her, who for herself will take no heed at all?

Publicity Campaign of the Shreveport, La., Registry Board

GENEVA A. PETERS, R.N.

DURING the World War and the influenza epidemic following it, there was a great shortage of nurses in this section of the country. It was especially difficult to find nurses who would go on duty in homes, on night duty, or into the rural districts. If we were able to fill these calls at all, it was with the type of nurse who could not get anything else to do and who took these calls as a last resort. This type of nurse may be readily recognized as the "misfit." The doctors for whom she nursed were dissatisfied, as were the people into whose homes she went, and a perfectly natural result of such a situation was that the doctors used practical nurses and, finding their services more satisfactory than those of graduate nurses, soon preferred them and grew to depend on them almost entirely.

As time went on, and the country settled down to normal conditions following the war and nurses became more plentiful, we began to find great numbers of nurses off duty, some of them for weeks at a time. We were not able to place them all in the hos-

pitals and we had very few or no calls from the doctors in the small towns in our district. One nurse, returning from a case in the country, brought us the news that the country doctors were using the practical nurse in preference to the registered nurse, saying that they found her more dependable and more satisfactory generally than the nurse who had been sent through our registry. Naturally, we felt this blow keenly and, after discussing it very thoroughly, we decided to try to make a "comeback" to the country doctor.

At a district meeting an appeal was made to the private duty nurses, who pledged their coöperation in filling these calls. This was in 1929, just a short time before the meeting of the Tri-State Medical Society in Texarkana. Cava Wilson, Secretary-Treasurer of our Registry Board, conceived the idea of going before this group of doctors and asking their coöperation in using our registry and nurses. Permission to send a representative to this meeting was obtained and Miss Wilson went, with the purpose of putting before that group of physicians the desire of the Shreveport District Nurses' Registry to supply them with efficient service in filling calls from both rural and urban areas.

A table was placed in the meeting hall on which was placed a placard about two and one half by two and one half feet with the legend:

The Shreveport District Nurses' Directory
Service Day and Night
Phone 8–4576

Cards were distributed with our fee schedules and general information concerning the directory. Several copies of the *American Journal of Nursing* were also displayed on the table. Constructive criticism was invited.

This was our first attempt at any form of publicity and our uniformed representative was most cordially received between discussions, when contacts were made. She was also invited to all dinners and social functions.

The warm welcome, the spirit of fellowship, and the promise of fullest coöperation from the doctors was most gratifying and so encouraged us that we sent a representative to the meeting held this year in Marshall, Texas.

We appeared also before the State Medical Society meeting, held in Shreveport this year. Jane Ingersoll, who represented the Association at this meeting, had prepared a map of Louisiana divided into districts. Each parish of the district was in a different color and each accredited school of nursing was reproduced in miniature and placed at its proper location on the map. Thus, at a glance, the districts, the parishes in the districts, and the nursing centers for the districts were seen.

Results: A happier relationship between our registry and the members of the medical society has been established, and a much better coöperation between these two bodies is enjoyed. The rural districts are being supplied with a better type of nurse, and employment is given to many nurses who otherwise would be off duty. Our Registry Board feels that it has been very richly rewarded for its efforts.

Sympathy

THE death of S. Lillian Clayton brought to the American Nurses' Association over one hundred letters, telegrams and cablegrams of sympathy, literally from all over the world.

The letters reflected the high esteem in which Miss Clayton was held by leaders, not alone in the nursing profession but in the medical and public health fields as well. Written in different languages, in varying forms of expression, the messages embodied the deep regret and profound sorrow at her death felt by those who knew the nurse leader, personally or professionally. They gave further proof that Miss Clayton was one of the best known and most sincerely loved in the nursing field in this, as well as in other countries.

Twenty state nurses' associations and six district nurses' associations, all close constituents of the nursing organization headed by Miss Clayton, wrote of the profession's great loss. One state association wrote:

> Our nurses feel that they have lost a warm and understanding friend. Miss Clayton was always ready to assist us in our problems and her advice and her help were always of a practical nature. Therefore, we feel that her death has taken from all nurses one who gave of her time and strength, and with understanding and great human kindness extended a helping hand to those less strong than herself.

Six United States public health officials, including the heads of the Army and Navy Corps, paid tribute to her high character and personality. Forty-one individuals, nearly all in the forefront in nursing and medical centers, conveyed to the American Nurses' Association their feelings of sorrow at the passing of one whose inspiring leadership they had appreciated and respected. Letters came also from allied nursing organizations and from hospitals whose contact with Miss Clayton had filled them with a great admiration for her sterling character.

From abroad came fourteen communications from presidents of national nursing associations, all affiliated with the International Council of Nurses, who felt that the loss to the nursing profession could not be estimated. From Asia, Africa, and South America, came seven communications which stressed, as does the following letter, their appreciation of Miss Clayton's wide range of interest, which included nursing problems all over the world:

> When it has been necessary to recruit staff members from America, we have often consulted Miss Clayton and, heavy as her responsibilities were, she was always willing to take the time to consider our problems and give us her kindly but penetrating views on possible candidates.

Many letters spoke of Miss Clayton's graciousness as a hostess. A Belgian nurse leader wrote, "I will personally remember her charming hospitality and all the kindness she showed me last year when I was in your country." From another source came the statement, "She was always most cordial and kind in giving visiting members of our nursing staff and faculty opportunities to see significant work in her hospital."

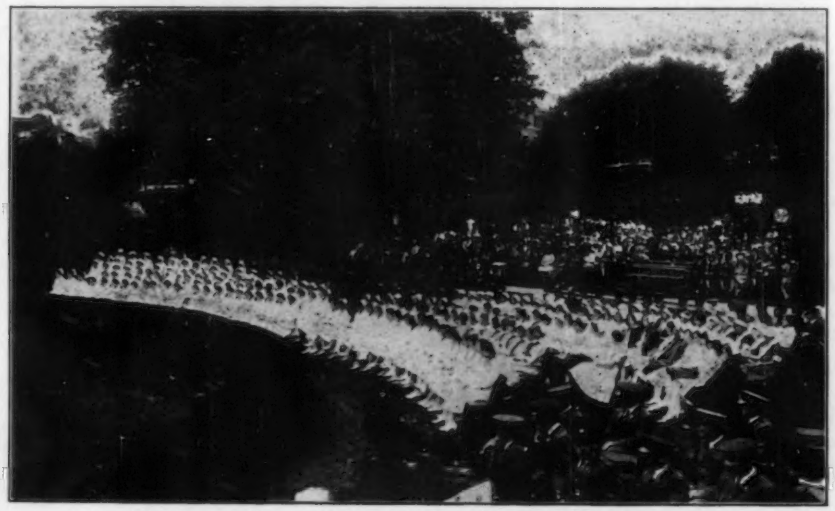
The general feeling, summed up, is reflected in the words of a South African nurse, who said:

> We truly feel that in her passing America and the nursing world have lost one of their great leaders, but we know that the inspiration of her teaching and example will continue to imbue the profession she so passionately loved and served.

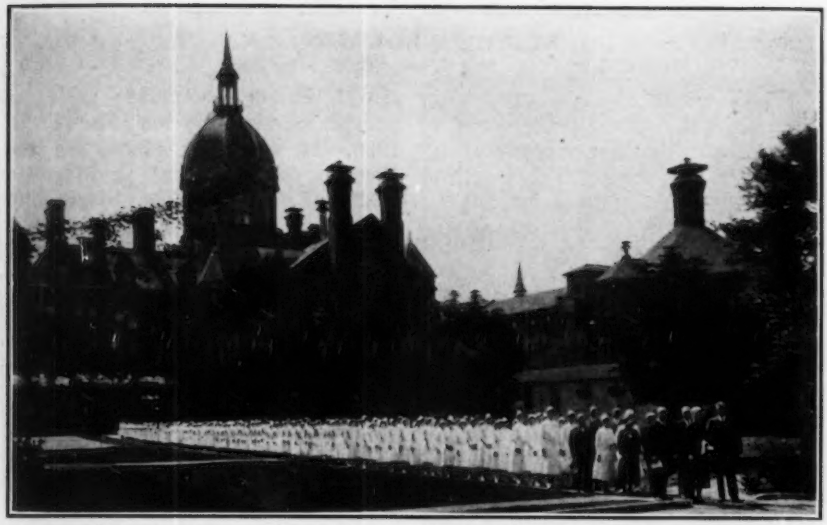
Outdoor Commencements

THE PHIPPS GARDEN AS A COMMENCEMENT SETTING

IT requires a certain amount of courage to plan for outdoor commencement exercises, but those who have done it report that only occasionally has the weather been unkind. Infinitely better, they think, to "take a chance" than to have an overcrowded auditorium or, ultimate tragedy for the class, no exercises at all. The charming pictures of the Johns Hopkins Hospital class of 1930 are typical of the exercises hallowed by



ARMY SCHOOL NURSES GRADUATING AT WALTER REED HOSPITAL



COMMENCEMENT AT JOHNS HOPKINS HOSPITAL SCHOOL OF NURSING, 1930
Dr. Winford Smith, Superintendent of the Hospital, and Miss Lawler, Superintendent of Nurses and Principal of the School of Nursing, leading the procession

years of tradition at that interesting place. By using amplifiers, class and guests, seated on the galleries around the four sides of the charming little "Phipps Garden," are enabled to hear perfectly.

Many years since, at the Newton Hospital, Miss Riddle established the custom, continued since her retirement, of erecting a marquee on the spacious lawn. Here successive classes have been, and still are, graduated with the benison of that gracious New England saint.

"Commencement in the garden" is crystallizing into tradition at the School of Nursing, the Presbyterian Hospital, New York City. The lovely green campus gives ample space for graduates and their friends, while at the juncture of two broad staircases curving up to the hospital is a platform for the speakers.

Smaller schools have adapted themselves to circumstances in various ways. At the Jewish Hospital, Cincinnati, although the exercises are held indoors in the evening, the reception for the class is held on the gayly lighted lawn.

Another Middle Western school uses a sunken garden as a setting for the "day of days." So, too, does the Army School of Nursing at Washington, D. C., as the picture so charmingly shows.

Indeed, no two nursing school commencements are quite alike. The setting may vary all the way from formal academic surroundings, the dignity of churches, or a school's own auditorium, to a garden. The completion of a nurse's training is a great event for her. Happy is she whose commencement is gracious, dignified, and full of promise.

Disability Bill for Army and Navy Nurses

J. BEATRICE BOWMAN, R.N.

THE nurses of the country will, without doubt, be interested in learning that nurses of the Army and Navy are now entitled to retirement if disabled in line of duty.

The struggle to procure this act has an interesting history.

One who has not had the privilege, or, to put it more accurately, the anxiety of helping to engineer a bill through the Congress of the United States cannot possibly imagine the efforts and struggles made by those particularly interested. The "good men in Congress" are individually and collectively at work on "the people's business," so when a bill such as ours is proposed it must, indeed, be a worthy cause. In this manner came to life a Disability Bill for Army and Navy nurses. It had many "*rebornings.*" I will give the data, but explaining why would take too long and probably would not be of interest.

The Honorable John J. McSwain, representative from South Carolina, first introduced a disability bill on December 7, 1928, and, to change its wording, re-introduced it on May 25, 1929, and again on May 20, 1930. The bill was referred to the Committee on Military Affairs. That we had interested friends all about us will be recognized by the fact that the Honorable Roy O. Woodruff, representative from Michigan, introduced a disability bill for members of the Navy Nurse Corps on June 8, 1929, and, with the advice of the Bureau of Navigation, re-introduced it on February 28, 1930, in order to give greater benefits. The bill was sent to the Naval Affairs Committee and was passed unanimously on March 13, 1930. It was then placed on the Consent Calendar and on May 19, 1930, was passed without objection by the House of Representatives, but with an amendment made by Mr. McSwain including the Army Nurse Corps. This gave us all great joy. The Senate passed upon it unanimously on June 11, 1930, and on June 20, 1930, President Hoover placed his seal of approval by signing the Act of Congress a little before the noon hour. This Act of Congress does not mean so much in money; that is, in comparison to the hundreds of thousands and millions that are appropriated, but it does mean a very great deal to the members of the two Corps who are now or who may be disabled. The Services have generously carried on the disabled members for years. They can now retire, be free to go forth in pursuit of happiness and health, with the knowledge that Uncle Sam appreciates the service already rendered and proves it by caring for them the rest of their lives.

The contents of the Bill is as follows:

That pursuant to regulations to be prescribed by the Secretary of War or the Secretary of the Navy, as the case may be, when a member of the Army Nurse Corps or of the Navy Nurse Corps shall be found by a board of medical officers to have become disabled in line of duty from performing the duties of a nurse, and such findings are approved by the head of the department concerned, she shall be retired from active service and placed upon the Nurse Corps retired list of the appropriate department in the grade to which she belonged at the time of her retirement and with retired pay at the rate of 75 per cent of the active service pay received by her at the time of her transfer to the retired list.

Chemical Hysterectomy

ELEANOR HELM, R.N.

THE scientific world moves so rapidly that it is difficult indeed for workers in the various fields to meet the changing demands. Especially is this true in the fields of medicine and nursing. These professions have always felt their interdependence, but at no previous time has so much been expected of the nurse in scientific understanding and skillful procedure. The nurse today not only must keep up with changing technic in her own field but must also be alert to opportunities to assist the physician and surgeon in his. Of the many new surgical procedures with which I, as a nurse, have been privileged to assist, a chemical hysterectomy is an outstanding one.

A hysterectomy is the removal of the uterus either by laparotomy or through the vagina. Within the last few years doctors in the field of surgery have successfully performed this procedure chemically instead of mechanically. Zinc chloride, the chemical employed, is an escharotic, and it is used in saturated solution. The entire uterus is not removed, as in former surgical procedures. The chemical causes a sloughing of the endometrium and part of the muscle wall, in the form of a cast.

Indications for such a procedure are many. It is used essentially to destroy an infected endometrium or cervix such as occurs in chronic infections of the uterus that resist milder therapeutic measures. It is also used to produce sterility in cases of pernicious anemia, tuberculosis, epilepsy, insanity, and heart disease. It has been proved that the cervix is the focus of infection in many cases of arthritis and secondary eye infections, and frequently, because it is the seat

CAST REMOVED FIFTEEN DAYS AFTER OPERATION

V. S. Counseller, in *Surgical Clinics of North America*, February, 1930. (Courtesy W. B. Saunders Company)

of a chronic streptococcic infection, it is associated with menorrhagia, metrorrhagia and leukorrhea. These conditions are most common among patients over forty years of age; the patients occasionally are obese and have chronic heart or kidney disease. In these conditions radical surgical procedures may be contraindicated because of complicating conditions which may arise postoperatively. The chemical hysterectomy has proved a safe procedure on the part of both the surgeon and the patient and still accomplishes the same result as a total abdominal hysterectomy.

The patient is prepared as for any

vaginal operation. In the operating room the first step in the procedure is to test the uterus as to size. This is done by firmly packing it with sterile gauze, which is then removed and the same amount saturated with the zinc chloride solution. The saturated gauze is firmly packed into the uterus. The cervix is held shut by two towel clips to prevent leaking of the zinc chloride solution. The vagina is then packed with a sterile soda sponge. Soda is a neutralizing agent and in this case it is used to prevent erosion of the vaginal wall due to any of the zinc chloride's contact with it. The zinc chloride is allowed to remain in the uterus from twenty-four to thirty-eight hours, generally thirty-five hours.

The nurse has during this time put into practice general nursing care, but at the end of the specified time she begins a special series of important but simple tasks. It is her responsibility to notify the surgeon in charge of the case when the pack is to be removed. Upon his arrival she should have ready a sterile tray containing the following articles:

1. Sterile douche can with either a hard rubber douche nozzle or a metal irrigating tip.
2. Sterile saturated soda solution, 110 degrees F.
3. Bivalve speculum.
4. Lubricant.
5. Rubber gloves.
6. Sterile sponges.

Other articles necessary are: a sheet for draping the patient, small rubber sheet, towel, douche pan, blanket and a convenient light.

The patient is placed in a dorsal recumbent position on her bed and properly draped as for any other vaginal procedure. A blanket is placed over her chest. The small rubber sheet and towel protect the bed under the douche pan. The light is placed or held in such a manner as to shine directly on the field of work.

The doctor inserts the speculum which has been well lubricated and under direct vision begins to remove the soda sponge from the vagina. While this is being done the nurse should have ready the soda solution in the douche can, and when the soda pack and clamps have been removed, the soda solution is allowed to run slowly into the vagina. This is continued while the doctor is removing the zinc chloride pack. After its removal another long, warm sterile douche should be given and repeated every four hours for a period of twenty-four hours, or longer if the physician so orders.

The convalescing period, following a chemical hysterectomy, is in most cases uneventful. The course is usually afebrile, because of the rapid action of the chemical, thus preventing any absorption into the general circulation. From ten days to two weeks after the pack has been removed, the cast, consisting of the endometrium and part of the muscle wall, separates and is discharged into the vagina, leaving only a thin layer of uterine muscle which soon contracts to about the size of an infantile uterus. It may be necessary to grasp the cast with tenaculum forceps and rotate it in order to completely separate and remove it. Usually it is expelled spontaneously.

During the hospitalization period the patient receives general nursing care. Upon her return from the surgery she may have fluids as tolerated. The second day she may have a soft diet and on the third day a general diet. If a retention urethral catheter has not been inserted during surgery, catheterization may be necessary. Following the removal of the pack the patient should have no trouble in voiding. Enemata may

be given on the second or third day postoperatively, if necessary. As a laxative, one-half ounce each of mineral oil and milk of magnesia is usually prescribed three times daily.

The third day the patient may sit up in bed, but she should remain in bed until a day or so after the cast has been removed. Postoperative hemorrhage rarely occurs, but should it occur at this time a light vaginal pack is sufficient to control it.

The procedure may be a simple one when compared with the usual hysterectomy, but very often, particularly because it is new, it causes the patient a great deal of worry. It is the nurse's duty not only to give the patient efficient nursing care but also to demonstrate that under her starched professionalism there beats a sympathetic heart and an earnest desire to help bring about a successful result.

The State in Relation to the British Nurse

HESTER VINEY, S.R.N.

As far back as the last quarter of the nineteenth century, a movement was made towards the state registration of nurses in England, but it was not until 1919, the year following the great war, that an act was placed upon the statute book giving to the nurse her legally recognized professional status.

This Act, which applied to England and Wales, is known as the "Nurses' Registration Act, 1919," and by it the formal machinery for regulating the training, conducting the state examinations and for registration was set up.

To carry out the terms of the Act, a General Nursing Council was established, consisting of twenty-five members, appointed as follows:

Two members appointed by the Privy Council, and of these members it is stated in the Act that they shall not be registered medical practitioners nor nurses nor persons concerned with the direction of or the provision of the services of nurses;

Two members appointed by the Board of Education;

Five members appointed by the Ministry of Health;

Sixteen nurses elected by the nurses whose names are on the state register, and these elections take place every five years.

The Chairman and Vice Chairman are elected annually by the Council and at the present time both offices are held by state registered nurses. The Registrar and Assistant Registrar and some of the other officials are also state registered nurses. The government department under which the Act is administered is the Ministry of Health.

The first duty of the General Nursing Council is to maintain a register of those nurses who satisfy the conditions laid down in the Act and in the rules framed under the Act. Up to 1925, registration was open to nurses without state examination, on adequate proof of training and experience. Many hundreds of nurses availed themselves of the terms permitting registration under these conditions. Since the period of grace expired, in 1925, the register has only been open to nurses under the following conditions:

1. The nurse must be twenty-one years old.
2. She must show a certificate or give satisfactory proof of her training in an institution or training school approved by the General Nursing Council.

She must have passed the examinations conducted by the General Nursing Council qualifying her to place her name upon the appropriate part of the state register.

The approval of institutions as

training schools for nurses is the responsibility of the General Nursing Council, which is charged under the Act with the duty of keeping a list of such institutions.

The schools are divided into those which are complete in themselves, offering all the necessary training and experience, and those which are affiliated or associated with other training schools which supplement their training facilities.

The following parts of the state register are maintained:

1. General part of the register for nurses trained in approved general hospital training schools.
2. Supplementary part of the register for male nurses.

Supplementary part of the register for mental nurses.

Supplementary part of the register for mental defectives' nurses.

Supplementary part of the register for sick children's nurses.

Supplementary part of the register for fever nurses.

The examinations for state registration are conducted three times a year in all parts of the country, and in the work approximately 300 doctors and 460 nurses are taking part.

The nurses enter for the state examination twice during their period of training: for the preliminary examination after not less than one year's training and for the final examination after the completion of not less than three years' training; in the case of fever nurses, not less than two years' training.

For the final examination, the nurse has to show evidence of:

1. Being twenty-one years of age;
2. Having passed the preliminary examination;
3. Having had adequate training and experience according to the rules governing the particular part of the State Register on which she desires to place her name.

The inclusive fees payable by the candidate for the examinations and registration are:

Preliminary examination, £2: 2: 0.
Final examination, £3: 3: 0.

The General Nursing Council has power under the Act to remove from the register the names of nurses of whose conduct they receive unsatisfactory evidence, whilst the nurse has the power of application for the restoration of her name upon the register, and for both actions a specific procedure is laid down. The state register is revised each year and the nurses pay a small retaining fee of two shillings and sixpence in order to keep their names on the register.

The General Nursing Councils for Scotland and Ireland were established simultaneously with the 1919 Act for England and Wales, but by separate acts for each country. Reciprocity was established with the three parts of the United Kingdom and has been continued with the Irish Free State.

The Empire, with its scattered population, naturally brought the question of reciprocity early before the General Nursing Council, and the following list is of interest in demonstrating the progress of a movement towards Empire reciprocity.

Reciprocity has been established with the following dominions and colonies:

		Arranged
New Zealand	Ratification	6 Oct., 1922
South Australia	"	8 Feb., 1927
Queensland	"	30 March, 1927
Western Australia	"	8 June, 1927
Burma	"	19 March, 1928
Natal	"	8 May, 1928
Victoria	"	25 May, 1928
Transvaal	"	19 June, 1928
Orange Free State	"	4 Dec., 1928
New South Wales	"	8 April, 1929
Tasmania	"	27 Sept., 1929
Cape Province	"	27 Sept., 1929

The General Nursing Council for England and Wales expects shortly to

receive the ratification terms for reciprocity with the South African Medical Council for the Union of South Africa which includes Cape Town, Natal and Transvaal, and the Act of 1928 was extended to the Mandated Territories of Southwest Africa on January 4, 1929.

The Act for Scotland is the "Nurses Registration (Scotland) Act, 1919."

The General Nursing Council for Scotland works under the Scottish Board of Health. The Council consists of fifteen members with the following constitution:

One member appointed by the Privy Council who is to be a person who is not a nurse nor a registered medical practitioner nor concerned with the provision of or with the direction of the services of nurses;

One member appointed by the Scottish Board of Education;

One member appointed by the Board of Health for Scotland;

Nine members who are State Registered nurses elected by those nurses whose names are on the Register.

The registration authority for Northern Ireland is entirely separate from that of the Irish Free State since the separation in 1922.

The General Nursing Council for Ireland was originally established under an Act of 1919. This was followed, after the separation of Northern Ireland from the Irish Free State, by a further act—the Joint Nursing and Midwives Act (Northern Ireland), 1922—under which the work of registration is now carried on. This new Act established a Joint Council in Northern Ireland for the purposes of the Midwives (Ireland) 1918 Act and the Nurses' Registration (Ireland) Act of 1919 and for all purposes connected therewith.

The Joint Council established by the Act consists of ten members:

Four persons appointed by the Minister of Home Affairs, who are as follows:

One medical officer of health;

One member appointed to represent the Councils and the Borough Councils in Northern Ireland in connection with the midwives;

Two registered medical practitioners representing the registered medical practitioners of Northern Ireland; and in addition six members elected by the registered nurses and midwives respectively of which four are registered nurses and two are qualified midwives.

The Joint Council is charged with the duty of maintaining the register of nurses in Northern Ireland, of conducting the examinations qualifying candidates to place their names upon the general or supplementary parts of the State register.

This Joint Council has also the duty of approving the training courses for and conducting the examinations of candidates who wish to qualify as midwives, and of maintaining the roll of midwives in Northern Ireland.

The influence of this legislation controlling the qualifications of nurses has been far-reaching. On the educational side the hospitals all over the country have made great efforts to qualify themselves as approved training schools. These efforts included the appointment of sister tutors, the reorganization of the training school, and many other alterations and improvements.

The hours of work for the nurses have been decreased and their standard of general and professional education considerably raised, and a large part of the more fatiguing domestic duties has been eliminated from their work.

The nurses have borne their full share of responsibility in regard to the examinations. For the preliminary examination, the entire examination is conducted by nurses except for papers on anatomy and physiology, which are set by doctors and marked by them. The oral and practical examinations are conducted by nurses.

For the final examinations, all nursing papers are set by nurses, the papers on medicine and surgery are set by physicians and surgeons, whilst the oral and practical examinations are conducted in each centre by one physician and one surgeon and two nurses. All examiners are paid definite fees and travelling and subsistence allowances according to a definite scale.

For the nurse, although registration is not compulsory and she can practice without it, yet the advantage of registration becomes more apparent each year. Many appointments are only open to state registered nurses, and in others preference is given to them. The general public are slowly beginning to understand the protection offered to themselves by the Act and a legal penalty is attached for unlawful assumption of the title of State Registered Nurse and for falsification of the Register.

A standardized uniform for the registered nurses has been approved and protected, the rule being that only the state registered nurses can wear it. A permit must be obtained from the General Nursing Council before the uniform can be supplied by the makers.

The status of the nurse in Great Britain has been greatly strengthened since 1919 by her advanced standard of professional qualification. The profession which, even within the British Empire alone, offers wide opportunity of service to nurses, is attracting into it year by year keen and well educated probationers whose training and experience will enable them worthily to carry out the increasing duties laid upon the shoulders of trained nurses.

Let There Be Sight

THE annual report of the National Society for the Prevention of Blindness bears the arresting title "Let There Be Sight." It is an unusually interesting report, from the picture of the adorable baby on the cover straight through its well illustrated pages.

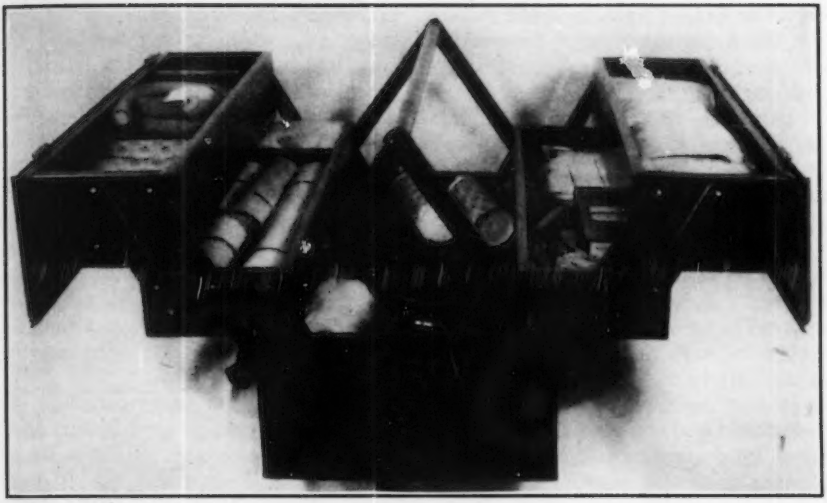
"We are especially concerned with the problems of that enormous number of children and adults, otherwise perfectly normal, who are constantly handicapped in their work or study and in their enjoyment of life because of defective vision," says the report. "With care, early in the life of a child, weak vision often may be strengthened or, at least, frequently kept from diminishing and perhaps being lost entirely. Science is teaching us that most of the causes of blindness are preventable.

"There are now 350 'sight-saving classes' for the education of children with seriously defective vision in the 95 cities of 21 states. Through the use of large-type books, movable desks, ideal lighting, and special teaching methods, children with little vision are not only given the same sort of education that children with full vision receive, but they are taught how to conserve their remaining sight. The Society estimates that approximately 5,000 such classes are needed in the United States. To train teachers for this work, special courses will be given in the coming summer months at Columbia University, the University of Chicago, the University of Cincinnati, and the State Teachers' College in Buffalo, N. Y.

"Trachoma, the disease of the eyelids which leads to blindness, continues to baffle the best minds of ophthalmology. Renewed impetus to research into the mysteries enshrouding it was given through a five-year program of investigation started recently by the Medical School of Washington University, St. Louis, and financed by the Commonwealth Fund. In addition to coöperation with the federal trachoma clinic at Rolla, Mo., during 1929, the National Society for the Prevention of Blindness assisted several other agencies in a study of the incidence of trachoma among the Chippewa Indians of Minnesota."

An Ambulance Emergency Kit

MARGARET PETERS, R.N.



THE kit was devised and constructed by W. J. Rogers, our chief engineer, and consists of a metal case 16 inches long, 8 inches wide, and 9 inches high. It is opened by putting the handles (located on upper portion of each side) in an outward direction.

Top Compartments:
- 5 assorted bandages
- 2 packages sterile sponges
- 2 packages sterile (flats) square gauze
- 1 roll adhesive tape
- 2 tourniquets

Middle Compartments:
- 4 rolls wide muslin bandage
- 1 medium roll of absorbent cotton
- 1 medium roll non-absorbent cotton
- 3 sterile hypodermic needles
- 1 sterile luer
- 4 ampules ergot
- 4 ampules pituitrin
- 2 ampules 1% silver nitrate
- 2 ampules 50% magnesium sulphate

Lower Compartments:
- 2 hot water bottles
- 1 large jar antipyrexol
- 1 medium can of starch
- 1 stomach tube
- 1 small bottle tr. iodine
- 1 bottle arsenic antidote

Insurance for Professional People[1]

JOHN A. LAPP, PH.D.

I AM indeed glad to speak before the American Nurses' Association again, and I am happier still that I am to speak to you on the subject of "Insurance for Professional People," for it is a subject that has been very close to my thinking for several years, and a subject upon which I have spent a good deal of time and investigation. I am not in any sense what would be called an authority on the subject. It is too vast a subject for any one to become an authority on in a brief time, but there are some aspects upon which I feel competent to express my views.

I should preface what I have to say by a brief statement concerning insurance itself. Strange, is it not, that insurance, so widely practiced, so widely bought, so widely used, is so little understood. Very few people really understand the simple principles of insurance, and yet they are indeed very simple. Insurance means merely that we collect, coöperatively, a certain sum of money, measured in advance, for the purpose of providing against a certain calamity that may happen to any one of us. It is not guesswork, it is not gambling; it is a scientific measuring of possible losses, and the gathering of funds adequate to meet those losses.

We know how many fires there will be in the course of a year throughout a large area. We know that from experience. We know what the losses are going to be. We know how much we must put into a fund if we are to pay those losses. We know how many accidents are going to take place in the course of a year. We know how much those accidents are going to cost in wages lost and in cost of medical care. We know, therefore, how much we must collect, a simple mathematical problem, to meet those losses. We know how many people are going to be sick in the course of any normal year. We know how long they are going to be sick. We know how much they are going to lose in time. We know how much medical cost, practically, there will be involved. Therefore, it is a simple matter to collect the amount necessary to meet those losses.

That, briefly, is an explanation of the simple principles of insurance. You can't get money out of a fund unless you have put money into it, and you can't pay the losses that occur unless you measure those losses and put into the fund enough to meet them.

We have four kinds of insurance that I think are of special significance to professional people:

1. Sickness insurance.
2. Accident insurance, including occupational diseases.
3. Old age insurance.
4. Insurance against death.

There are other forms of insurance useful to professional people, but not so useful as these. We might insure our bank deposits. Perhaps we haven't any. We might insure ourselves against defalcations of our subordinates, but perhaps we haven't any subordinates. We might insure ourselves against a number of other things but, essentially, to professional people, sickness, accidents, including occupational diseases, old age, and death, are the things against which we need to insure.

Looking at these particular causes of disaster, we find that they are all

[1] Read at a general session of the American Nurses' Association, June 11, 1930, Milwaukee, Wis.

measurable. We do know what is going to happen in any large group of people with respect to all these matters. We know how many people are going to die at any given age. We know how many people are going to live to old age. We know how many are going to live after sixty-five. We know about accidents and we know a good deal about occupational diseases, but not enough. We know about sickness. The losses are measurable. Therefore we can determine in advance what it will cost to meet the losses and devise the means by which those losses can be cared for.

I would begin first with respect to insurance against death, this being the least important for most of us, unless we have dependents depending solely on us. There are no great reasons for death insurance beyond the necessity of burial, for those who do not have dependents or those who must depend solely upon them.

I am not very much concerned with death insurance in my discussion here for two reasons: first, because it is not so essential to the bulk of professional people, excepting those who have dependents; second, because we have had a very considerable measure of insurance against death already developed. The magnitude of the life insurance business, as it is called, is very great indeed.

Turning to the subject of sickness insurance, we need to have a broader, a wider development. We have very little sickness insurance in this country, and most of that is limited to the people who need it least. We have practically no health insurance for the great masses of people who need it most. Yet sickness is a measurable calamity that we can determine with great accuracy.

I understand that there are about 80,000 nurses in the American Nurses' Association. Well, during this coming year, if it is a normal year, 20 per cent of the nurses in the American Nurses' Association will be sick for a period of more than seven days. Sixty-four thousand of them will escape during the entire year any serious illness. This coming year 16,000 nurses will be sick during the period of the given twelve months. They will be laid up for more than seven days. Of the 16,000 who are sick, only 35 per cent, or 5,600, will be sick for any considerable length of time. Fifty-six hundred nurses of the 80,000 will, in the course of the next twelve months, assuming it to be a normal year, have a sickness lasting over thirty days. About 500 or so will be sick for more than six months and of that number a certain percentage will be sick for more than a year, beginning sometime during the coming year.

It will be seen from these figures that the total amount of sickness is small, but it will be observed that the bulk of the burden of sickness is borne by the people who are sick for more than thirty days and especially by those who are sick for more than sixty days, ninety days, six months, and a year.

Sickness, then, being measurable, being a calamity that falls unevenly upon people, is a thing that especially calls for insurance to meet it. Likewise with accidents. We know about the extent of accidents, and fortunately we have to some degree provided for accident insurance through workmen's compensation systems. But in the case of nurses, workmen's compensation does not apply, except where nurses are employed by hospitals, or by industries, or by schools, or public departments. Nurses ought to receive compensation for all kinds of accidents and for

diseases contracted in the course of employment, from the workmen's compensation fund. But the bulk of nurses are employed by individuals and in such cases workmen's compensation does not apply. As a rule it applies only where there are three or more employees and in the case of nurses there is usually only one employee in the family where a nurse is working. So the bulk of the nurses do not get protection under the workmen's compensation law, in the case of accidents and occupational diseases, as the laws now stand.

Let me interject right here a recommendation. I do not know what the American Nurses' Association may have done upon this matter in the past, but I commend to them the very serious and systematic study of the subject of workmen's compensation as it relates to nurses in case of accidents and occupational diseases. I think as a rule it will be found that an occupational disease contracted in the hospital is considered an accident. The subject is well worthy of study because it ought to be provided, in some way or other, that every nurse, no matter for whom she may be working, whether an individual employer, a hospital, an industry, or a school, should receive compensation for that which is plainly and clearly an accident occurring in the course of employment.

There is next the subject of old age, a baffling subject. In all lines of work we find today men and women being discarded from employment and being thrown upon their own resources, to live out a lengthened time of life. We have increased the length of our lives. We live fifteen or sixteen years longer than the generation that was born only twenty-five years before us. We are going to live much longer than we do now. The number of people past sixty-five increases not only in proportion to population but much faster. There are half a million people over sixty-five years of age in the United States in excess of what there would have been if the conditions of twenty-five years ago had continued to prevail. Five hundred thousand people over those normally expected to be employed must be provided for.

I do not know how the changing conditions are going to apply to professional people, especially to nurses. The American Nurses' Association, the business of nursing itself, the professional nursing business, is not old enough to give us much of an indication as to what is going to happen in old age for the nurses. Whether or not men and women, especially women, will be employed continuously in old age we cannot tell. Whether or not the nurses will be affected as much by this change that is affecting everybody else is hard to say, but I am of the opinion that it will affect them very seriously. It is quite probable, though, that they will be able to find employment as long as their physical ability lasts, so in old age it is quite likely that it will be a problem of physical disability rather than one of employment and rather than one merely of old age.

Provision for sickness, accident, and old age is the very minimum if we are going to have that kind of security which human beings ought to have. It is a sad thing that men and women must face the kind of uncertainties that they now face. It is sad because it isn't necessary to face these uncertainties. It is possible through insurance to meet the risks of sickness, accident, and old age, meet them adequately, meet them in such a way that all may approach the future with a degree of confidence that, come

what may, they are not going to be driven into poverty and dependency.

There are at least four ways in which professional people can be insured: first, individual purchase from a private insurance company; second, social insurance through the state; third, group purchase of insurance; fourth, mutual insurance of a group through its own organization. These four methods prevail in the carrying of insurance and I should like to speak briefly about each one.

Individual purchase from a private insurance company is the method that has been generally used. One can buy almost any kind of insurance, even against bad weather. One can buy insurance against any possible calamity. But the individual purchase of insurance has two very serious defects: first, the people who need it most do not buy it; second, if they buy it, it costs too much, more than they can afford to pay. Insurance managed by a private company must provide not only for the expenses and losses but also a profit for those who are engaged in the business. Individual purchase of insurance falls down exactly where it ought to be strong. It falls down in that it doesn't reach the masses.

Social insurance through workmen's compensation against industrial and occupational diseases, through mothers' pensions, in cases of mothers having dependent children, and through old age pensions and old age annuities, is a form of insurance that is slowly but surely developing in this country. Workmen's compensation is now found in forty-five states, in varying degrees of efficiency. Mothers' pensions are now found, I believe, everywhere in the United States. Old age pensions are rapidly spreading, and are already found in at least ten or twelve states of the Union. Three of the greater states, Massachusetts, New York, and California, have recently provided for state-wide systems.

This form of insurance, however, does not meet the immediate needs of professional people, except in the case of workmen's compensation. It does not meet the needs of nurses who especially want to have, not the minimum of protection to prevent them from going into poverty or destitution, but the minimum that will make for a decent and comfortable living in the case of calamity happening to strike them.

The third method is group insurance, group purchase of insurance. This group in front of me, organized together, could go out to a life insurance company and buy for the group the kind of insurance it wanted. It could go to the insurance company and buy health insurance without medical examination, taking the members as they are, the strong with the weak, the physically fit with those who are not so physically fit, averaging all together. This group could go out and buy accident insurance, life insurance, or old age annuities for the group as a whole. They could buy anything that was wanted by a group and for far less than it would cost individually. Moreover, by buying in a group all people will be included, the weak with the strong, those who wouldn't buy it individually as well as those who would. The whole group would be in, and when a calamity happened to any one, all would bear the burden. The individual would not suffer the whole loss.

The fourth method, the method of mutual insurance of a group by itself, through its own organization, is essentially the group method carried out through a mutual plan without the aid of a commercial life insurance

company. The American Nurses' Association, or a state association, or a local association, might decide that a mutual insurance plan would be developed and that all should be protected against sickness, old age, or accident.

The four methods provide rather broadly for the insurance of professional people in those things which they need insurance for most, but, of these, social insurance, group insurance, and mutual insurance are the three most essential or most valuable in carrying out the program.

What shall we accept as our basis if we are going into the social or mutual insurance business? I am glad to note, in the report of the committee just presented, that a clear distinction is drawn between relief funds and insurance funds. Your fund today is a relief fund and not an insurance fund. As was explained, there is no relationship between the losses and the amount paid in. The amount paid in is whatever is paid in voluntarily. The amount paid out is whatever is paid out to those who are selected by one process or another for benefits. It is not an insurance plan.

If you are to establish an insurance plan for the purpose, there are certain principles that must be followed. First, rates must be adequate. You can't get something out of nothing. You can't get more out of the fund than you put in. There is no way under heaven by which that can be accomplished, and yet that has been the curse of all insurance. People have thought that insurance was magic, and that there is a fund, as some people think there is in a bank, and that all you have to do is to go and draw a check on it, never thinking that the cash must be put in before the check is drawn.

It is strange that intelligent people should not see that, but I have known scores, hundreds, of my friends from time to time in the past who have been misled by fabulous stories of what they were going to get back, little realizing that one couldn't get back more in the long run than had been put into the scheme.

Rates must be adequate to meet the measured losses that you are insuring against. If you know what sickness is going to cost, then you know that you must provide so much per member in order to pay those losses definitely upon a fixed basis.

Secondly, premiums must be automatically collected. You cannot depend upon voluntary payments by individuals of their monthly or yearly dues. If you do so depend, you must have a corps of collectors who go around continuously, as in the case of the burial insurance companies, going from door to door, collecting week by week and month by month, making certain that everybody pays, in order that if the calamity comes they may be protected.

Premiums must be automatically paid, and, in the case of the American Nurses' Association, a local nurses' association, or a state association, premiums for whatever insurance was to be carried might be collected as part of the dues.

Third, all members must be covered. If you are to have a mutual insurance or a group insurance plan, if you are to have insurance in a life insurance company as a group, or if you are to have a mutual insurance plan, then all the members of the group should be included. If they are not, you are likely to have left out just the ones who are going to have the greatest need for the insurance when calamity strikes. Moreover, it is likely that, if you do not include everyone in the group, there will be, if any process of

selection is used, by self-selection at any rate, those who are perhaps the weakest needing the insurance most, the most unhealthy, for instance.

Fourth, guesswork must be eliminated. There is no place for guesswork in insurance. Insurance is a scientific business and there is no need for guesswork. The actuaries in the different insurance companies work out with a nicety of mathematical precision exactly what it is going to cost under given circumstances. There is no gamble about it; there is no guesswork about it. If it is based upon guesswork, it is built upon sand. Yet it has happened in the course of time that even very able men have mistaken at this point the simple principles of insurance.

A few years ago, Andrew Carnegie provided insurance for aged professors in colleges, by creating a great fund, evidently without any consideration on the part of the men who formed the plan, or Mr. Carnegie himself, that there must be precise working out of the costs. It was demonstrated in a few years that the original plan had to be abandoned; it had to be put upon a basis of mutual support, in order to meet its obligations.

Teachers' insurance plans have been developed in numerous states and cities without any regard to what it was going to cost.

I do not suppose that I have any special call to recommend to the American Nurses' Association exactly what they should do, but there are some things that I might suggest, at least. In the first place, nurses ought to have insurance. I don't know of any group that needs insurance more than the nurses. They are in a hazardous business. They are in a business that is hard. They have certain advantages on the medical side, in that they are close to medical care. They may be able to get medical care cheaper and better and perhaps get it entirely free. They have that advantage over a great many people outside, but the uncertainties of their profession, the fact that they are not connected with any group that can be insured as a group, other than themselves, make it necessary that something be organized for them. We have, as examples, the teachers, policemen, firemen, public employees, and numerous other groups to copy from in the formation of such a plan.

Specifically, I do not think it is feasible to run a national insurance plan for 80,000 nurses scattered all over the United States. I don't think it is feasible for doctors, for lawyers, or for college professors, or any other group scattered the way they would be throughout the entire country, to run an insurance plan. It is already demonstrated how difficult it is to run a relief plan that way. It may be that it is too great a task to run a state-wide insurance plan through state associations of nurses. I cannot say, but I rather believe it is. It is certainly within reasonable expectations that a plan could be established in any given district association of nurses where the group is within range, where there is a mutual interest, where the members can protect themselves against those who might be fraudulent in their intentions, though let me interpolate here the statement that there are very few dishonest people in this world. Let me interpolate the fact that in the case of insurance there are comparatively few, so few that we can consider that it is negligible in our plans though, of course, it must be safeguarded, who would take advantage by any means of malingering.

But you say that possibly it is too

uncertain, the group is too small in a district association of nurses. Here is a suggestion concerning the organization of mutual health insurance, because for the time being that is the most essential of all these forms of insurance; namely, a local group, organized on a mutual health insurance plan, including all the members of the association within the area, that would be in some way coördinated with a state group that would form a sort of super mutual association, to protect the local associations against possible disaster through the calamities of epidemics. And the national association might use its funds for the purpose of safeguarding individual groups and state groups from financial losses and disasters, as a sort of emergency insurance.

Lastly, and here is the work I think for one of the great foundations, one of the foundations might provide for the planning of such an association; such an organization might stand behind in the experimental stages of the work to be organized; such a foundation might be prepared to help in times of financial troubles, and thus to safeguard the building up of a scheme of insurance that would be financially sound.

These are merely suggestions. Upon the one subject of insurance itself, I have no hesitation in recommending to everyone not merely that they have insurance but that they have it on a social scale, in order that the benefits of the insurance may be more widely spread. We do need to have a broad scheme of health insurance for all our people, but I think that will come only through the development of mutual and group arrangements of the different professions and organizations. We are finding it, incidentally, in the Milwaukee Street Railway and Light Company, and in scores of other organizations, where a mutual system of health insurance, including health care and, of course, the loss of wages, is provided. We need to extend that through all groups, so that the calamity of sickness will not take its toll so constantly, so that it will not continue to drive men down, to be that cause which is estimated to be something like 35 to 50 per cent of the cause of all poverty.

We know the problem; we know how it can be handled. All we need is the practical common sense to organize in such a way as to make it most economical, to make it serve us, and to make it most broadly social in its effect.

I should welcome the sight of a great body of people so intimately related with problems of health as the American Nurses' Association embarking upon this particular type of project. My suggestions are merely tentative. Your committee has been working bravely at the subject. It has come to sound conclusions, such as you heard this morning,[2] as to where you stand today. While it is not my province to recommend, I do suggest the possibility of a broader extension of schemes of insurance, gradually emerging from the health insurance side, until you have covered all the other phases of insurance, covered all the problems that make for disaster within your ranks.

[2] Presentation of the report of the Relief Fund.

Discussion of Dr. Lapp's Address on Insurance for Professional Groups[1]

EMILIE SARGENT, R.N.

DR. LAPP stated that there are four types of insurance of interest to professional people: that is, sickness, accident, old age, and death; and that at present there are four principal methods of procuring these four types of insurance: through individual purchase; through state legislation, such as the Workmen's Compensation Act, and the slowly developing legislation on old age pensions; group insurance, which is purchasable by employed groups from reliable insurance companies; and fourth, a mutual insurance of a group itself, that is, where the members create their own insurance protection.

From the point of view of the Michigan State Nurses' Association Study of Insurance, our committee has put its hope and its emphasis on the education of the individual to purchase her own insurance and to create her own savings account. Dr. Lapp points out the weakness of this measure inasmuch as it fails, usually, to reach those who need protection the most. He states that group insurance reaches more of the masses and is therefore more desirable.

The Michigan State Nurses' Association has laid its problem before four or five outstanding life insurance companies. Not one has offered to insure us as a group because we do not have the employer-employee relationship which is required by group insurance.

We have not thought of entering into the fourth plan of mutual group insurance because it involves an outlay of too much money, and we are not at all sure that a professional group should build up its own insurance plan. Until some more satisfactory plan has been developed, Michigan will provide a relief fund which will be administered as any case-working agency administers relief. Thorough investigation will be made, using the local official and non-official relief organizations, when advisable, to rehabilitate the nurse who needs this type of assistance; or, if a small gift or loan of money is all that is necessary, it will be given from the Michigan Relief Fund to members living within the state.

The Insurance Committee firmly believes that the individual nurse can be interested in insurance and saving and that it is the association's definite responsibility to make it possible for her to secure information along these lines. Any state association can carry out much the same plan as we have in Michigan. We are fortunate in having state headquarters, with a full time secretary and certain helpful equipment, such as an addressograph machine. We publish a monthly bulletin which is sent out to the individual members and to the training schools. You will see that it is easy then to reach the individual member by bulletin and by letter. It is well to remember that if you have a committee, with a financial adviser, endorse four or five good savings plans and insurance plans, these companies will be glad to bear the expense of mailing their literature to the individual members of the state association. They are also glad to pay for advertising space in the bulletin; they are also willing to buy space to exhibit

[1] Given at the Biennial Convention, June 11, 1930.

at a state annual meeting and to furnish a speaker for the program if desired. They are just as willing to send speakers to district meetings. The professional organizations are merely the means of putting the company that has a good financial plan before its nurse members. In our state, the Harmon Foundation and the Insured Futures, endorsed by the Bankers' Trust Company, have sent their literature to our individual members at their own expense.

The thought which impressed me, as I listened to Dr. Lapp's very interesting and stimulating presentation of this problem of professional insurance, is the fact that those groups which have successfully taken out group or mutual insurance, are professions wherein the largest numbers are in salaried positions; for example, the teachers and social workers; even the trades groups and the city employees, such as firemen, police force, etc., are salaried groups. In the nursing profession, 60 per cent are non-salaried workers, who collect for their services by the day and whose work is seasonal and unstable.

The question in my mind is whether or not we should try to make a plan to fit this 60 per cent, as they are the group who need protection the most, or would it be more constructive to reduce the number of non-salaried nurses? The reports from the Grading Committee all point to the fact that the nursing profession needs stability of employment. We have agreed with the Grading Committee that hospitals should employ more graduate nurses on a salary basis; that there should be nurses organized on a full-time salary basis to go into homes to give part-time nursing, or so-called hourly nursing, in our cities, and it is hoped that such a plan can be worked out even in our semi-rural communities. We probably shall always need a surplus of nurses for peak periods of illness, and if these nurses were affiliated with bureaus of nursing, now called registries, our insurance plan would solve itself, for any organized group where the employer-employee relationship exists, can take out group insurance. Likewise it is much more possible that the nurse on a steady income will be able to individually purchase her insurance and keep up her own savings plan. Therefore, when we have carried out the suggestions of the Grading Committee, the problems of our Relief Fund and our insurance question will have solved themselves. The task is in our own hands. Our alumnae, district, state association members can do much by keeping this topic alive and using every opportunity to promote it in the membership and to interest the lay people in their community to support us in our effort to become economically stable.

How Public Schools Can Help

THE public schools can help the nursing profession by: First, acquainting the pupils with the opportunities of nursing; second, discovering and encouraging those who are interested and qualified; third, providing them with every opportunity to lay a broad foundation for the training school and the professional career; fourth, building into their characters the high ideals of personal conduct and social service demanded by the profession.

I urge you to go into your own community and through organization, conference, and if necessary petition, secure these services from your own public schools if they are not already provided.—Worcester Warren, Superintendent of Schools, Bridgeport, Conn., before the State Graduate Nurses' Association.

The Grading Reports Are Mailed!

RECENT visitors to headquarters have been gently led by the hand, and invited to come and peek at the Grading Committee. It has been a sight worth watching, and very far indeed from resembling anything which people usually think of as a staid statistical research office. The grading reports have been getting into the mails.

Early in May the first steps toward the actual mailing job were begun by the preparation of large manila envelopes. As will be remembered, each school had been invited to send in the names of those people whom it wished to have receive copies of the confidential report for its school. Somewhat to the consternation of the Committee, this invitation was accepted so eagerly that some schools asked not only for three or four copies, but for twenty, or thirty, or forty, and even up into the seventies. All told, there were 10,500 people whose names and addresses were submitted to the Grading Committee with requests that they be sent marked copies of the confidential report. Envelopes had to be prepared for all these people.

In order to handle this part of the job, the Committee ordered gummed labels, printed with the name of the Committee in the corner, and arranged in long strips with perforations between, tightly rolled with 1,000 labels in each roll. Typists laid these rolls behind their machines and ran them through, one label after another, without being obliged to insert each separately. As these rolls were finished, they were passed along to other groups of workers, who checked the typed address with the hand writing on the original report from the school. How the Grading Committee workers blessed those superintendents who filled out their reports on the typewriter or printed the names by hand! After the labels had been typed and checked, a third group of workers tore them apart and pasted each upon a large manila envelope. All of this work had been done in May, and the boxes of envelopes have been piled ceiling high in the storage room, waiting for the great day to come when the first report would be printed and ready for distribution.

On the first morning back in the office, after Milwaukee, word came that huge wooden packing cases were waiting to be delivered. Where could the material be put? There was no space in Room 1647, for that has for months been filled to capacity with extra workers and their paraphernalia. The packing cases contained the grading reports, and the supply of blank reports for each state contained certain pages which were different from those in the reports for other states. It was, therefore, necessary to find some vacant areas where forty-nine different piles of reports could be laid out and kept separate from each other. Any one familiar with the crowded conditions at headquarters can understand the dilemma.

It was the New York State Nurses' Association which came to the rescue. "The New York nurses," said Miss Hicks, "are delighted to coöperate with the Grading Committee. We gladly offer you our floor." The offer was instantly accepted. One after another the great packing cases were wheeled down the hall and pried open. The fifteen members of the Grading Committee staff, in Indian file, made a never-ending chain, passing the packing box, picking up a bundle of blank reports, carrying it into Miss Hicks' office, placing it on the floor in its proper location, and scurrying out again for another load. Within half a

day all of the reports had been unboxed and piled, but there was practically no space left in the New York State Nurses' Association office!

The next call was for fifteen fountain pens to be loaded with red ink, for bottles of red ink, and sets of ink eradicator, the last very much in demand. A master sheet had been prepared for each school, indicating the rank of that school on each of the major items reported upon in this first section of the grading study. A special corps of workers took these master sheets and one green report book for each school. From the master sheet the worker located where each of the ninety or so red ink entries was to appear in the green book. She made the entries and another worker checked everything she did, so that there was prepared for each school one master copy in which every red ink entry had been verified. Then came the rush job. Each worker received a master sheet and a master copy, together with as many blank copies as the school had requested, and proceeded to make red ink entries as rapidly and as accurately as she could. The mailing began with schools on the Western Coast and worked eastward, in order to make the dates on which schools would receive their copies as close together as possible.

The work spread out. It is no easy matter to make identical red ink entries in, say, twenty books when the workers are sitting so close together that they hardly have elbow space. Drawing boards were brought out and balanced between desks and upon card tables, to furnish extra writing space. An appeal for an unoccupied room resulted in permission to use the little dark, unventilated cubby hole where motion pictures are sometimes shown. New electric light bulbs and a baby fan made the place habitable, and the actual filling, sealing, and mailing was transferred there. As the copies for each state were finished, inserted, and sealed, progress was noted on an office diagram in which the black portion represented how far the work had gone. As the black portion grew steadily day by day, there was mounting excitement in the Grading Committee office. Ten thousand five hundred copies is a large number. They called for 945,000 red ink entries. The stamps alone cost $1,470. The empty envelopes, packed tightly together, before they were filled occupied twenty-two large corrugated paper cartons. When filled, sixty-six mail bags were required to carry the load.

Nearly one-third of all the schools joining in the study received individual letters from Stella Goostray, who has been appointed by the Joint Nursing Committee on Educational Policies to coöperate with the Grading Committee in this work. Miss Goostray transferred her office from Boston to the New York headquarters, and has been burning the midnight oil in her determination to have her part of the material ready in time to go out with the main reports. Great cardboard cartons of Goostray letters have been carried up the long aisle from her office to the Grading Committee office, and there has been a careful matching of letters with reports.

Besides the reports to the individual schools, sample copies, with the identities of schools concealed, but marked to demonstrate the method used, have been sent to each member of the Grading Committee, to the leading nursing and hospital magazines, and to the secretary of every state board of nurse examiners. All of this work is in the last stages as this article is being written. Long before the printed copy of the August *Journal* reaches its readers, the last mail bag will have

been filled and the Committee staff will be hard at work, preparing Section 2 of the Grading reports.

Letters are already beginning to come back from schools which have been among the earliest to receive their copies. Two bewildered trustees have written, stating that they have received the reports but do not know which schools are referred to. In order to protect the identities of schools as far as possible, it has been necessary to refer to each school by its code number only, since to have red ink copies traveling through the mails or lying on desks with the names of the school written out in full, would inevitably mean that some people, who should not, would gain access to the material. Word is being sent hastily back to these trustees, telling them which schools the reports fit. One of them has reason to be bewildered, since he is trustee of three schools, all sufficiently alike in size and type so that he cannot separate the reports.

A few letters question the figures reported by the Grading Committee, the writers apparently forgetting that the results are based upon what they reported a year ago. Conditions have changed in their particular schools since. Several letters from superintendents of nurses and from hospital trustees have been written to thank the Grading Committee for its service in making available a clear and simple discussion of problems concerning the student body, and stating that the writers are waiting eagerly for Sections 2 and 3 of the report. Still other letters are raising questions as to what they themselves should do. Some of these letters are being referred to Miss Goostray for specific help. Present indications are that Miss Goostray and the Grading Committee staff will be busy women for the rest of this summer. It is hoped to have Section 2 of the Grading Study ready for consideration by the Committee early in September.

Samples

From the Early Acknowledgments of the Grading Committee's Findings

I AM impressed with the uniqueness of the presentation, with the ingenuity with which the content is assembled, with its continuity, and with its general soundness. . . . I wonder if I may have an extra copy of the report?—*Superintendent of a Famous Metropolitan Hospital.*

A *jolt* is the only way to describe what the report gave me, a disturbing, self-satisfaction-jarring jolt. . . . The grading is valuable, suggestive, salutary and cause for heart-searching and stock-taking. We are grateful to you for it and shall hope to profit by it immediately.—*Head of a Famous School of Nursing.*

It is inspiring. It verifies the weakness we have known, and I am sure the report will be a great help in showing our directors where we fail and persuading them we need to do better.—*Director of Nursing Service.*

I intend going over it fully with our Superintendent of Nurses and then take the main points of interest before our Training School Committee, prior to submitting the entire report with any recommendations to our Board of Trustees.—*Hospital Superintendent.*

. . . while I find it of great interest I am disposed to dissent from its general findings, because I feel that the present situation with us is far better than is indicated in your analysis.—*Hospital Superintendent.*

. . . inasmuch as we are limiting the admissions to our school, and supplementing our nursing service with graduates, and nurse helpers, I am sure you will feel that serious thought has been given to the problem of oversupply from our standpoint.

Our fall class of thirty, which are fifteen less than the corresponding year of 1929, consists of four-year high school graduates from

academic courses, all of whom have attained a yearly average of 83 and over.—*Director School of Nursing.*

A survey of this kind will be a real assistance to us in directing our endeavors in the future. I have discussed the matters contained in the report with the superintendent of the training school as well as with officers of the hospital. You may expect to hear from them within the next few days.—*Hospital Trustee.*

I am greatly interested in the ingenuity and effectiveness of the scheme which you have adopted for signaling with your red checks the relationship of a given school to the others included in the study. All together it seems a most interesting and usable report.—*Hospital Trustees.*

This institution was modest in its request for copies of the report, asking for only four. Since that request we have a new president and a new chairman of the School Committee. May I therefore ask that copies be sent to them? . . . If possible, in addition, I would like to have three copies sent to me, two for our School library, so that our graduate staff and student body may become familiar with it, and the other to be loaned when the occasion arises.—*Director School of Nursing.*

This is the cleverest report in which I have had any interest that has ever come to my notice. I wish to compliment you upon its form and its content. While we were fully cognizant of our own shortcomings, your presentation of them will be helpful, I am sure, in their correction.—*Director School of Nursing.*

The compiled statistics as noted therein affords a very helpful and interesting study. . . . May we ask that you accept the enclosed check for $20 as a slight token of our appreciation.—*A Sister in Charge of a Nursing School.*

I have received a confidential copy of the "Results of the First Grading Study of Nursing Schools" . . . I am wondering if possibly this was sent to me in error, as it seems to be something about which I have no knowledge. Am holding the copy for your reply.—*Hospital Trustee.*

It was a stupendous undertaking, but I believe the results will redound to the betterment of our nursing system. Personally I feel it will be a great incentive for all of us to do more efficient work.—*Superintendent of Hospital.*

We do think it was very fair. We are, of course, somewhat disappointed that we got such a low rating in many of the points taken into consideration. However, we have made many improvements along all phases of educational, social, and physical standards since the last estimate and I sincerely hope that we rank very much better in the next rating.

I think the grading is a splendid step and I feel that it will have a stimulating effect on the entire profession as well as aiding in the relief of unemployment and better distribution.

I am more than willing to give any amount of time to the raising of the standard in our school and I feel that every member of the faculty is likewise.—*Superintendent of Nurses.*

N. O. P. H. N.'s New President

SOPHIE C. NELSON (see frontispiece) is the newly elected President of the National Organization for Public Health Nursing. Miss Nelson is a graduate of the Waltham Training School for Nurses, Waltham, Mass., and has held the following positions: Infant Welfare Nurse, Neighborhood House, Cambridge, Mass.; Director of Nursing, Boston Health League; Superintendent, Visiting Nurse Association, St. Louis, Mo. Present position: Director of Nursing Service, John Hancock Mutual Life Insurance Company, Boston, Mass.

Miss Nelson also has a record of brilliant war service. In November 1917, when the Chateau des Halles near Lyons was being made over into a convalescent home for the repatriated children of France, she went to it as chief nurse. Later, as the work of the Children's Bureau for Lyons expanded, Miss Nelson was appointed chief nurse of that district, with Dr. Clifford Grulee as medical delegate.

Still later, in 1921, she became general director of the Red Cross nursing service in the Balkan States, Austria, Hungary, and Serbia, remaining as representative of the Red Cross nursing service in Eastern Europe until the last of the field nurses were withdrawn.

Miss Loveridge Retires

AFTER forty years of arduous, consecrated and constructive service for the Good Samaritan Hospital, Portland, Oregon, Emily Lemoine Loveridge has retired to private life. A native of New York State and a graduate of the Bellevue School of Nursing, Miss Loveridge went to Portland in 1890 to become superintendent of nurses in the first school of nursing in the Northwest. Miss Loveridge's work was truly pioneer, for the hospital of which she became superintendent in 1905 gave little promise of becoming the stately and widely useful institution it has grown to be, in its setting of fine old trees and charming gardens.

The lonely young superintendent might have been less homesick in those first months of adjustment, could she have foreseen that the time would come when the hospital world would acclaim her "a dean of hospital administrators" and would welcome her to its highest councils, and when

nurses, not only of the Northwest but of other parts of the country, proudly would do her honor.

Some of Miss Loveridge's "Reminiscences," quoted from the Bulletin of the American Hospital Association, may be found in our "Miscellany" for June, but many pages would be needed if the complete story were told. In a very real sense, Miss Loveridge became a leading citizen of Portland, or, as she modestly put it, "the hospital had large community interest." She tells, for example, how "During one year of unemployment, we aided the unemployed by furnishing one hour's work for each meal, our own employes acting as foremen for a given number of unemployed. We painted, calcimined, scrubbed, washed windows—did anything to give them employment enough to earn a meal."

With such a spirit of broad charity animating and directing all activities, with administrative powers that balked at nothing needful for the institution, it is small wonder that the hospital and Miss Loveridge have held the affectionate and grateful interest and support of the people of Portland and of the State through the years.

In her resignation Miss Loveridge said, in part:

> Forty years is a long period, and having completed that period of time as superintendent of Good Samaritan Hospital and superintendent of the Nurses' Training School, I am desirous of retiring to private life.
>
> It has been my pleasure to see the hospital grow from a cottage type hospital to the metropolitan proportions of the Good Samaritan Hospital today. My life has been largely woven into the fabric of the institution and it has a very dear place in my heart. It has not been an easy thing to come to a decision to give up my labors, which have been so long and so pleasant, but I feel that I should like to have the few remaining years of my life to do the things which I have not been able to do these past four decades. I intend to make my residence in Portland, although I shall leave soon for the winter in the East among relatives and friends.

The affectionate esteem in which Miss Loveridge is held by the Board of Directors, of which Bishop Sumner is chairman, is substantially shown by their provision for her future. Miss Loveridge retires on full salary. She is to be succeeded by Carolyn E. Davis, who has won distinction in the Northwest as Superintendent of the Minor Hospital, Seattle, and, more recently, in a like position at the Everett General Hospital. Miss Loveridge has the satisfaction of turning her work over to one whom she admires and has long called friend, one who brings vision, vigorous enthusiasm, and the fruits of arduous preparation to the new task.

Miss Fitzgerald's Appointment

ALICE FITZGERALD, "internationalist," has been appointed Director of Nursing at the Polyclinic Hospital, New York City, beginning August 1. Miss Fitzgerald has had wide administrative experience both in this country and abroad. She helped to organize schools of nursing in Serbia, Czechoslovakia, and Poland, was adviser in nursing on the staff of Governor General Leonard Wood in the Philippines, and of late has acted as nurse consultant to the Siamese Government to reorganize the school of nursing of the university hospital at Bangkok.

Age of Mothers in Manhattan

SURPRISING facts regarding birth statistics in Manhattan were disclosed in a report by the health commissioner, who showed that although the child-bearing age is normally between the ages of seventeen and forty-five, in 1928, twenty-four babies were born to mothers who were children less than fifteen years of age and, equally amazing, ten babies were born to women beyond the half century mark. Of the total of 42,382 births in Manhattan in 1928, 25,370 were born to mothers between the ages of twenty and thirty.

Some Specialists

Anna L. Gibson, R.N.

MYRA B. CONOVER, R.N.

IT is a matter of course to hear the directors of training schools for nurses say: "We welcome the young nurse into our schools. She is so enthusiastic, so eager, so intense, so quick to grasp opportunities. It is she who blazes the new trails—trails of which the more mature nurses never dreamed." This is true in general, but some of the older nurses are still setting a high standard for the "young nurse," and outstanding among these is Anna L. Gibson, Superintendent of the Collis P. Huntington Memorial Hospital, Harvard Medical School, Boston, Mass.

Miss Gibson, as was then expected of the youngest daughter of a large family, after completing her high school education remained at home as companion and helper to her elderly mother. When she was thirty years of age, a widowed sister offered to take her place in the home, for she longed to become a nurse.

When she entered the Boston City Hospital Training School for Nurses, in 1905, she took along her beloved old violin—a few weeks later she was an enrolled student at the New England Conservatory of Music. However, the study of music did not interfere with the study of nursing. In those days, theoretical instruction in nursing was limited, and no stress laid on case reports and so on. Nevertheless, Miss Gibson, in her daily notebooks, kept a complete record of her patients, current comments, clever pen sketches, and frequent, apt verses.

Bachrach

ANNA L. GIBSON, R.N.

Wherever and whenever a thoroughly dependable nurse was needed, Miss Gibson was assigned to duty. Not only did she always meet that responsibility but she always found

time and opportunity to get something worth while out of it. While a charge nurse on a contagious ward when a severe epidemic of diphtheria swept the city, she volunteered on her time off duty to assist with the preparation of the "culture slides." This opened the door of the clinical laboratory to her. She soon realized that this field should be open to all nurses; that for a nurse to carry out her duties intelligently, she must have the knowledge that only a course in the clinical laboratory could give.

Miss Gibson resigned as Matron of the East Boston Relief Station, in 1914, to accept the Assistant Superintendency of the Collis P. Huntington Hospital. This was a new hospital for "research for the cause and treatment of cancer and allied diseases." Here she found a most congenial atmosphere. The doctors quickly recognized her capabilities and, as they were selected from the faculty of the Medical School, she found the various departments open to her.

Ever true to her profession, she began sharing her knowledge with the staff nurses. At the direct request of the medical profession, she started regular classes for nurses in routine clinical technic. Later, she accepted also many college graduates whose education had fitted them for this line of work. As no charts or textbooks were available for this group of students, she published her own.

During all this time she continued to broaden her own field of knowledge. She became deeply interested in the cancer problem and the study of tumors of the lymphatic system. Here, under the direction of the late Dr. Francis W. Peabody, continued under Dr. George R. Minot, one of the largest leukemia clinics in America was developed. In this work Miss Gibson took a most active part, becoming one of the best informed authorities on normal and abnormal blood cells and blood constituents. Whenever an unusual blood abnormality is found, doctors continue to seek her opinion.

Throughout all her work the importance of accurate records was insisted upon. For clinical work nothing is better than photographs. As the hospital could not afford the services of a first-class photographer, Miss Gibson mastered photography also. She follows the patient, from appearance on admission, on the operating table, or with radium applicators in position, the surgical specimen *in toto*, and the patient at subsequent intervals. Not only does she do this work for the hospital, but for the private patients of the staff as well.

As an executive, she is able and capable. She has kept herself informed along the most modern business lines by successfully completing courses in employment management, factory service, and other allied subjects at Boston University.

In conclusion, just a glance at the human element side. Miss Gibson is in charge of a cancer hospital. Stop and think what it means to the average patient to go to such a hospital! Miss Gibson thinks of that. Special stress is laid on the way every one from the door girl to surgeon greets and treats the patient. So far as is possible, the courtesy and friendliness of a home are found in her hospital. One example of this: in the rear of the hospital is a large flower garden. The plants and bulbs are supplied by the staff; Miss Gibson and her nurses, working together, care for them to the end that daily the nurses may take these flowers to their patients.

A noble life, well spent and full of inspiration is hers.

Editorials

An Anniversary

JUST ten years ago the tiny infant that grew into the present extensive, though unimposing, National Nursing Headquarters was born. Only a few nurses appreciate the courageous efforts which made that simple statement possible.

"Almost from the beginning of our organization life, the need for Central Headquarters has been talked of, first by one group of members, and then by another, but there has never seemed to be a time to begin when all the conditions were favorable," wrote Miss Palmer in a *Journal* editorial in March of 1920.

Clara D. Noyes, laboring under the Herculean burden of post-war adjustments in the American Red Cross Nursing Service, was President of the American Nurses' Association. How she found the time and the courage to pilot the association through one of the most important developments of its history, she alone knows. Under her leadership, and despite the opposition of the selfish and the timorous, the long-felt desire crystallized into action when the Red Cross, which had established a Bureau of Information to meet the emergent needs of nurses returning from war service, decided that it was inadvisable to continue the service as a Red Cross activity. The nursing organizations were invited to consider taking it over. After careful consideration by a committee of which Miss Nutting was Chairman, and on which sat representatives of the three nursing organizations, this was done. Space was found at 156 Fifth Avenue, New York City, where the National Organization for Public Health Nursing was already established, and the Bureau was transferred from the local offices of the Red Cross. This was more than a mere transfer of function. The Red Cross provided complete equipment for the new office, financed the project for a year, and R. Inde Albaugh, who had been doing an important part of the placement service, became the director of the new office which, in addition to the placement and recruiting activities already under way, took on definite duties for the American Nurses' Association and the National League of Nursing Education. Space does not here permit a description of Miss Albaugh's heroic work for which the profession owes her a tremendous debt of gratitude for, according to a *Journal* editorial of August, 1920, the A. N. A., the N. L. N. E., and the American Red Cross were jointly represented, in the new office.

It is of particular interest at this time that this move was felt to be of urgent importance because of the need for a nation-wide recruiting campaign "*not only for the purpose of securing students, but for making better known the proper standards of nursing education and for enlisting the support of the public in maintaining them.*" The findings of the Grading Committee show how ably the first of these three objectives was fulfilled.

The report of Miss Nutting's committee outlined joint activities and suggested that there were three ways

by which the Headquarters might be administered.

1. Pooling of resources and personnel, and investing responsibility in a committee with proportionate representation.
2. A federation of the bodies concerned with a central committee which shall be advisory.
3. A combination of these two plans by which certain interests and expenses shall be shared, others handled by each association, under the direction of a committee which shall act as a Board of Trustees. This is the plan recommended.

No such comprehensive plan was put into effect, but some of the principles were made effective through the Joint Boards. In 1921, N. O. P. H. N. and the embryo headquarters, which shortly separated into A. N. A. and N. L. N. E. offices, moved to the present location at 370 Seventh Avenue, New York City, chosen because the building housed the National Health Council, with its sixteen organization members. The placement of public health nurses became an activity of the N. O. P. H. N. and later of the Joint Vocational Service. The placement of nurses for institutional positions was taken over by the League and in time discontinued. Working coöperatively on an ever increasing number of projects, the administrators of all three organizations and their staffs, and the editors of the *Journal* have consistently endeavored to work out broad gauge programs. As Miss Taylor, then Executive Secretary of the League, said in her report in 1923: "We are trying to think in terms of the big thing we represent in the project for which we exist, rather than the organizations of which we are the secretaries."

In other words, each nurse who has, or has had, the privilege of working at National Headquarters has endeavored to expand her thinking to include not only the clearly defined activities of her own organization, whichever it happened to be, but also an appreciation of the programs of the others, and to think toward an ever increasing pooling of facilities and of knowledge in ways effective for the whole profession.

The developments of the ten years have been interesting and important. The N. L. N. E. has twice moved in order to provide space for its staff, now numbering three workers, the Executive Secretary, Nina D. Gage, a secretary, and a bookkeeper. It has had three executive secretaries during this period, Miss Taylor, Miss Pfefferkorn, and now Miss Gage. Services rendered, which, because of the small staff, have to be rendered almost entirely by correspondence, fall into three groups:

1. Organization correspondence, including work for the committees.
2. Vocational guidance, particularly for a large number of prospective students.
3. A medium of exchange between over burdened educational workers, for the results of studies and experiments in the field of nursing education.

The A. N. A., from that small beginning ten years ago, now has a staff of ten professional and non-professional persons working under the direction of Janet M. Geister. Agnes Deans succeeded Miss Albaugh; and Miss Geister, Miss Deans. The Association distributed at the convention a booklet, "Your Fifty Cents," which tells of the extreme care with which every penny of income is expended and of the scope and variety of the work. For example, "In 1929, 15,650 letters were written by the headquarters staff, 2,649 pages of mimeographed material were sent to the states, 95 copies of the President's Portfolio were issued, 22 convention packages were sent to the states"—all this in

addition to extensive field work, the study of registries and other activities.

The National Organization for Public Health Nursing brought its magazine, the *Public Health Nurse*, from Cleveland and incorporated it in its headquarters activities. Ella Phillips Crandall, Anne A. Stevens, Florence Patterson, Jane Allen, and Katharine Tucker have successively directed its activities. It has a staff of ten professional and eleven office workers. Briefly, its major activities are as follows:

1. In its special field the N. O. P. H. N. continues to serve as the standard-making body and central bureau of information.
2. To individuals and agencies it offers an advisory and consultation service.
3. Special studies are conducted by its statistical department and committees.

The *American Journal of Nursing*, beginning with a small office and a part-time secretary for the editor, has now consolidated its editorial and business offices with a staff of seventeen, all under the roof of "370."

Headquarters is a friendly place where visitors are always welcome. Student nurses come in classes; graduates singly or in groups, depending on their errands or their interests; professional and other guests from foreign lands are fairly frequent, for it is not only in our own country that "370" is thought of as a center of American nursing. There are also those who come seeking special types of nurses for important posts and those who come for advice on nursing programs. Nurses come with perplexing personal problems. It is a happy task to meet such guests and many of them more than repay for time expended by offering stimulating suggestions, by indicating new developments, and, in short, by sharing experience.

Personnel and space occupied are only one means of measuring growth. The recent Biennial, with its carefully coördinated, but varied, program, was a magnificent expression of teamwork at headquarters. It is significant that the executive secretaries, instead of pausing to enjoy that success, began to work, as their trains sped eastward, on plans for extending the service in new ways and for strengthening those services already established.

These are troublous times in nursing. There is general unrest among nurses and the profession is suffering from exceedingly uncomfortable growing pains. Each day brings reports of constructive programs and of work well done. Every mail brings expressions of the difficulties to the workers at headquarters. Energetically, faithfully, zealously, your representatives toil—some of them often far into the night—to meet the needs, to help solve the problems, to make studies, to hold the profession steady on its course of ever-growing usefulness and in steady effort to maintain and improve professional standards and to assist the individual, through whatever channels may be suitable, to find durable satisfaction in her service. We cannot be too grateful to those courageous and far seeing leaders who studied the needs, made plans, and showed the way.

The officers at headquarters are not superhuman. It is not always easy for overburdened nurses to see clearly the larger implications of the task. It requires keen intelligence and generous thinking to see over the barriers of one's own organization and realize that coöperative effort is needed or even, occasionally, that a task might more successfully be accomplished under the direction of another organization. But, year by year, the quality as well as the quantity of service to the profession and those whom nurses serve increases.

At the close of ten arduous years,

with clamorous demands and urgent needs yet unsatisfied, it is important for us to evaluate the almost incalculable service to individuals, and to individuals through component organizations, that has been rendered. We pause only to acknowledge our debt to those who labored that the principle of coördinated effort might be established in surroundings which would make such effort fruitful.

The officers at Headquarters enter upon the second mile with a record of substantial service as a background, with careful plans for steadily expanding service, and with high hopes for the future. A splendid start has been made on the program outlined by Miss Nutting and her committee. What shall the next ten years show?

Miss Hall To Go in the Field

AT the last minute before our pages close, word reaches us that the Board of the Peter Bent Brigham Hospital of Boston has granted Carrie M. Hall a five months' leave of absence. This is splendid news, for Miss Hall is to conduct an educational campaign for the Harmon Association for the Advancement of Nursing. She will be available for state meetings, and makers of programs should communicate with her at once. It is a rare opportunity for nurses to hear from this nurse who has devoted much time to a study of the Annuities for Nurses made possible through the Association.

Miss Hall was President of the National League of Nursing Education when Mr. Harmon, out of sympathy for nurses who seemed to him to need guidance in making their later years secure, made the proposal which resulted in the present plan. She was made Trustee of the Association and is also a member of the Executive Committee. She is exceedingly well-informed on the whole subject of economics for nurses.

As all nurses know, Miss Hall speaks with a direct simplicity that carries conviction. Her acceptance of the appointment which involves as much travel as can be compressed into five months is a matter of congratulation. Her message is a needed one. Her usefulness will be in direct proportion to the opportunities provided for her to meet nurses in groups. There is general agreement that, as a profession, nurses are not yet thinking as carefully as they should of providing for their own futures. Miss Hall is prepared to show a way.

To the Students at the Biennial

L. L. Dock, R.N.

WHAT message can I send to you, the younger generation? You have already had everything said to you! But, as I grow older, I realize more and more what an immense value there is in learning to perceive the romance of your lives as you go along through life. To have an insight into the springs and sources of the human characters you meet; to store your minds with material for stories, novels, poems and history; living pictures, and tales of adventure. This gift cultivated, with the sympathy and compassion of your profession, will banish dullness from the most routine tasks.

(Some of the authors of textbooks, who had been invited to meet the students who attended the Biennial in Milwaukee, sent greetings.)

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY NINA D. GAGE, M.A., R.N.

Supervision[1]

W. H. BURTON, PH.D.

I WOULD begin by presenting a very general definition of supervision. Supervision is an expert, technical service designed to improve the efficiency of groups of workers under supervision. To teachers, the technical business of supervision is to improve the efficiency of the classroom teacher or to further the chief business of education which is the learning process in pupils. You can translate that for yourselves better than I can.

The business of supervision with you is to improve the efficiency of people in training or of those who have completed their training but are still doing technical work where oversight is needed.

I will go further and quote another definition, from Fannie W. Dunn of Teachers College, well-known in the field of education, who has defined supervision very nicely in one long sentence. I like it because it stresses the major point in supervision and then breaks it up into the ideal and the common-sense views. It is very skillfully done:

> Instructional supervision has the large purpose of improving the quality of instruction, primarily by promoting the professional growth of all teachers, and secondarily and temporarily, by correcting deficiencies of preliminary preparation for teaching by training teachers in service.

[1] Read at a general session, June 13, 1930, at the 36th Annual Convention of the National League of Nursing Education.

Thus, primarily, supervision should promote the growth and the development and the better efficiency, personal and professional, of the people under supervision. Primarily it should do that. But we all know that, with the people we usually supervise, either their training wasn't complete, or they themselves are not completely up to par, and for various reasons we have to develop and correct deficiencies and to give specific directions as to what to do.

You can translate that, of course. The chief business of supervision in your field is to promote the growth of the people under supervision by any means that you can; to train them to take initiative, to take responsibility, to think for themselves, to go ahead on their own, and so on. But, secondarily, you are going to have to correct those people, to train them in service, tell them what to do, and correct them in their deficiencies.

So far I have presented general definitions. Specifically, how do we do these things? I shall give what I like to call a master definition, not because it is a master in the sense of being perfect and inviolable, but it is a master definition in the sense that it is pervasive and reasonably complete.

Supervision does four things in the main: *First*, inspection. And I stop there for just a minute to postulate that that isn't all it does. Too often

that *is* all it does, particularly in education. I don't know how you feel about it, but the first thing that supervision does is to inspect. It has to get facts. It must know the status; it must know what is going on. I will say how in just a minute.

The *second* thing that supervision does is training. That is, having inspected, obtained facts, discovered the situation, its needs, its weaknesses, its strong points, then supervision plans a definite program of training for the people in the situation, the training aimed directly at the situation, at the needs and deficiences of the people. I shall elaborate on that at the end of my talk.

The *third* thing that supervision does is guidance. Some people don't see very much difference between training and guiding. I will make a distinction for you. In addition to guiding the workers, that is, in the sense of training them, telling them, directing them, it is also well always to lay plans and supervision programs for the stimulation of initiative and responsibility.

I said a moment ago, Guide the workers in trying things out for themselves. Because I do not know your work, or what you can do in this field, let me take two minutes to present a situation from education, and perhaps you can parallel it better than I can.

In the teaching field, in addition to training our teachers and telling them what to do, we want to stimulate the best teachers to try things out for themselves, to experiment with methods of teaching. I can see that it would be very dangerous to experiment in your field in the giving of medicines or in trying out certain treatments but, as I say, I am not sure of the details there. In education we do try to have the teacher go beyond the routine, to figure out things for himself, to express himself.

The *third* major function of supervision would be guidance in the sense of stimulation and encouragement of initiative, and participation, and thinking on the job.

There is a *fourth* thing that supervision does, and in the field of education this is really deep water and I anticipate it will be for you, because we can't do much of it under practical conditions. The fourth thing supervision does is to carry on a little practical research on the actual, immediate problems of the situation. I do not mean extensive pure research, such as the discovery of truth, but I do mean that the supervisory staff, be that staff one worker as an individual, or a dozen, or fifty, has as one of its inescapable obligations the obligation to do more than furnish a guide. Many problems ought to be met by carrying out some practical research procedures. Again, I can't illustrate from your field, but I can illustrate from the educational field at considerable length.

Let me go back and go over those a bit. I want to say some things about them. Let's go back to the first one, inspection. In the good old days in education, I suppose also in your field, supervision consisted of inspection. You probably have among your workers a slang term that was tacked on to those who did supervision. They call it "snoopervision." You doubtless have heard that. But that embodies a good deal of truth as regards the old type of supervision. It was detective work, it was "gumshoe" work, it was catching the worker, it was watching the deficiencies. That is almost entirely wrong. But I do want to point out that inspection, properly conceived, is still one of the four major, important, and basic functions of all

supervisory officers, but with different technic, and with a totally different spirit.

In education we inspect by giving tests and using rating cards. I suspect you have rating cards. We inspect by visits. We go around and see things, take a look. We inspect by interviews, we inspect by checking with three or four advisers, and so on. At any rate, there are four or five legitimate data-gathering technics. You have them in your field. These are operated to find the facts. They are not operated to catch a worker, to trip a worker, to embarrass a worker; they are used to find, impersonally, the actual status. I mean by "status" what work is developing, what work is middling, and what work is poor; what work has not carried over with some people or with all people, what new things are needed in the situation, new equipment, new regulations, new adjustments of hours and loads and duties, and so on. That is inspection today. It is operated in an above-board, fair-minded, modern way, for the sake of coming in touch with the situation in which the people under supervision are working.

Inspection, of course, involves not only the personalities of your people and their actual technics; it involves also their equipment—their physical equipment, their arrangements of hours, their distribution of duties and functions and responsibilities, and I haven't the slightest hesitation in saying that it might involve also their personal lives outside of the actual clinical and hospital work.

Of course teachers always resent that and I am sure your people do, too. Very obviously, workers do dissipate their time and they, very obviously, cannot be at a high level of efficiency on the job. Within reasonable, decent, fair limits, inspection extends beyond the actual rooms of the laboratory or clinic where you do your inspecting.

What is the purpose of inspecting? As I have said, to find the facts, to know the situation, particularly the weaknesses, deficiencies, and possible betterments.

That leads right up to the second major function, the training of the workers. I want to point out that, in the old days in education, visitation—visiting the workers, going to see them—was a major phase of supervision and it probably was with you. It is not major at all. It is one of the functions for finding facts. You never can supervise properly by visiting a nurse, or a clinical worker of any sort, and helping her at the time, then visiting the next one and helping her at the time, and the next one. That is patchwork supervision. It is good, to be sure, if you have nothing better, but it is random, it is desultory, and haphazard. It is not conclusive and coherent and consecutive. That is, the training program of supervision is not a haphazard affair of training this worker. If this will help him, it is good, to be sure, but I want to point out the great possibilities of organizing for a period of six months. In schools we do it on semester, quarterly and yearly basis. I mean the organizing for a long period of time of a definite program of training. Your inspectional procedure this year with the group of nurses you have now may reveal that their needs are these, and these, and these. Last year your class was particularly good in two of these points and poor in something else. Therefore, for each year, whether you divide it into quarters or six months or any given periods, you organize a program of training based upon the needs of that particular group.

I will discuss that part of my talk,

that technic of training. You directly improve the worker on the job and then you inject into the training program certain things which we may call the general improvement of the worker in service. Let me illustrate from teaching, as I know that best.

In the training program with teachers we do two things. We train them and improve them in the direct performance of the classroom acts, we give them training in the direct technics of teaching. We give them training in things other than the direct classroom technics. We give them supplementary reading. We have conferences on things not directly concerned with the actual technics but remotely concerned with them, background material; we even sometimes have to give attention to health and recreational agencies of training.

Let's go to the third thing. I am not so sure this holds for you. I am a little bit in doubt here on the matter of guidance in education. We stimulate the better teachers to take on experiments, to help us plan the program of supervision, to make suggestions as to what ought to be done in supervision.

Then in your tentative suggestions, in so far as you can, you will guide your better people to assume responsibility, to develop beyond the routine level, and to look forward to better positions and better types of work. You will pick out the better teachers and stimulate them to look for promotion, and further training, and advancement.

There is one item in guidance in education, however, which is vitally important, and which I have no doubt does apply to your field as well. One of the items under guidance in supervision is the extremely important business of developing and maintaining morale, professional spirit, esprit de corps.

As we go about the country we find many good school situations but we find in the same cities mediocre and poor school situations. We are almost ready to say, in education, that the good school buildings are always to be found where you have a fine principal at the top. Pretty nearly every time you may have very good teachers but, unless they are stimulated, led, guided, and inspired by good leaders, they only do average work. Here and there, of course, individuals stand out. In this business of developing morale, esprit de corps or fine professional feeling and spirit, the supervisory officer can contribute one of the greatest things to the efficiency of the worker and the betterment of the general situation.

How do you develop morale, esprit de corps? That is important enough for me to take a minute or two. There are differing technics for developing morale. One is, of course, to maintain a personal attitude which is fair, sympathetic, kindly, and tolerant.

I shall never forget a young woman who came to my office in tears. I was assistant superintendent in a little city. She came in with her troubles and began to cry. She cried a bit and couldn't tell me what the trouble was. I tried to encourage her to tell me what it was all about. She had had trouble with her principal, no explanation, but this is what I got out between sobs: "He bellows at me." She didn't have to say any more after that. Even if he were dead right he had no business in the principalship, and we had to tell him so.

Any group of workers, no matter if they make awful mistakes, are entitled to a courteous hearing the first time. If they repeat the same mistake, then you can be as rough as you

want to. But the attitude of the person who leads, directs, guides, helps, corrects, should be one of sympathetic understanding. That is an enormously important item in maintaining morale.

Second is this: Within the limits of time and energy, the supervisor should give help when it is needed. That poor frightened young teacher, who had caught herself in a jam, needed assistance. She needs assistance right now. It may not be the time, or it may not be the best time, for you to tell her not to get into that jam again. But help willingly and happily when it is needed.

The third thing is even more important and has a very grave implication. The third way of developing and maintaining morale is to ensure that the supervisory staff themselves know their stuff. That is, a supervisor has a difficult job. She ought not only to know the difficulties but she must know some suggestion to offer. They must really be sure on some of the things that are constantly coming to them in order to help beginners, people in training and new people. The fact that a supervisor knows, and is sure and confident, has a great deal to do with getting the support and enthusiastic following of the people under supervision.

To go back to my last point—research. As I say, that is deep water for everybody. In educational work we talk about it and we know how to do it, but we don't do much of it because we don't have the money nor the time. We are trying to do it. I suspect that in your field, as time goes on and it develops, and as you get more time and more money and more help and more equipment, you can undertake, on the job, certain minor or practical pieces of experimental tryout.

I very often ask if we in the professional field aren't as bad as any other. I can use an illustration in your own. I had to go to a hospital and was astounded at the professional level of nurses. I was there quite a while. It was a painful and unpleasant business, but I learned a great deal and I had a lot of fun.

I was staggered by some of the leading physicians in the hospital. One of them used a new instrument to remove tonsils. He showed it very proudly around the staff room. One or two of the older surgeons, men of consequence, wouldn't look at it at all. One said, "I have been doing it this way for twenty-five years, and it has been quite successful, and I am not going to fool with anything else." Needless to say, he didn't do any operating on me.

I was astonished, but we are just as bad in teaching. The worst thing you can do is suggest to an old-timer something that has come from a scientific laboratory, because she knows it is wrong before she has tried it. I wonder how many of these practical school administrators know this new education is wrong and are sure it is wrong. I wonder how they know, because they never tried it out.

To go back, in your field you can try out some of the new things. Where it is dangerous, it is going to get you into trouble. You can try some experimental technics, you can try out new things. I can't talk your language very well, but, at least, I can stress the research point of view.

To summarize: The functions of supervision are to inspect the situation. On the basis of that, to give the workers guidance, which is merely direction, training, help, and assistance; then guidance in the sense of stimulation. And, lastly, do such research as you can.

I want to develop four other points

which contrast traditional, old-time supervision with modern, scientific supervision. There are other points; these are the four most important, to my mind.

In the first place, modern supervision is not confined to visiting and conferring with the worker himself. Supervision today is an extensive, complicated, and far-flung program, involving many things beyond visiting the worker.

As I pointed out earlier, visitation will get you into a round of patchwork and of random and desultory supervision. Mark well, lots of it is good, it is very helpful at times, but the help is not continuous, but piecemeal.

Supervision today rests upon a planned program of objectives and means of attainment.

I want to make this second point. Traditional supervision was inspection. Today it is help and assistance and encouragement.

The third contrast (and I am sure this holds true for you as well as it does for us) is that traditional supervision was usually done by one person. Today in education from two to twenty people may supervise a given group of workers. And I think, from what little I know, you ought to have several supervisory contacts. Two or three judges are better than one, and two or three instructors, or two or three people planning, training, and guiding, are better than one. Let me put it this way: Traditional supervision is usually done by one person; modern supervision is usually a coöperative undertaking of two or more.

The last and fourth contrast in points that I will make is this: Supervision is not imposed from above. It is not authoritarian. Mark well, it directs from above when it has to. There must be authority up there, but supervision develops out of the situation, supervision develops out of the need of the workers under supervision. It is not imposed from above by a staff, but it is based on what the staff finds in the actual situation.

Those are the four points I wanted to make. I did not have to bring them out a great deal in detail, but I mentioned them for the sake of emphasis, and perhaps it may clear up one or two points for some of you. I assume that most of you in this audience accept supervision; that is, you don't argue about it. You believe in it, in the main. In education, as you know, until just recently we have had to fight for supervision. In this decade it is all right; we get by with it now. But until recently supervision was under fire, under suspicion. To the word "supervision" teachers were very antagonistic. Many of the old-timers still are.

I want to develop three or four reasons why supervision has taken hold.

In the first place, supervision is an accepted business principle in any complex human undertaking; that is, any undertaking in which several people work together needs unification and coördination. It is quite normal for people to differ in the way they do things, in the way they envisage the end, in the way they think of achieving those ends. In complex and important business it is necessary that somebody be responsible for unification and coördination. It is an accepted business principle.

One of my graduates brought in, the other day, a set of score cards from a dairy company which distributes milk and dairy products all through this region. They have score cards just as we do. They have rating cards, they have inspectors, they have little booklets that tell how they improve the morale and efficiency of their

workers on the farm or wherever it may be. They have supervision.

Some years ago, in Cincinnati, I had an interesting experience in renting my home for the summer to a gentleman who came there to be the head of one of the life insurance agencies. I turned over my home to him and told him, of course, to use anything there was in the house. In looking around the place he found some books on supervision. As it happened two or three of them were mine. I did not think he would read them. In fact, I thought he wouldn't. He picked one of them up during the summer, and when I came back three months later he told me, very proudly, that he had presented to his company an organized plan of administration for a supervising agency, for insurance agents all over America. He presented it to the home office in New York and, with some modifications, the plan was adopted. It is now in use in that insurance company all over America, and others follow it.

The point I am making is that supervision is an accepted business principle in many business corporations. The trained nurses and even the physicians have some sort of professional supervision, though it isn't of the rigid sort that we have.

The second is that among educators, the workers in business fields are presumed to be on a level with nurses. I suspect that the best trained nurse is undertrained in this country still. The best trained in all these fields is undertrained, in terms of an ideal, so that supervision is necessary, because the average worker in any field is not a highly trained individual.

The last reason I would give is particularly true in education and I suppose it is with you, too; that even if the worker were trained, she could not keep up with the new developments in the field. In education no school teacher could attempt to keep up with the developments in the science of education. She has to have an agency, a supervisory staff, which reads, digests, and corrects the new material to the level of the classroom worker.

That is enough on supervision, its functions, the contrast of the old and new, and the reasons for it. I am going to break away from that and present my last point.

In this connection I have mentioned several times the fact that supervision should be a planned program. Let me go through it rapidly. This is too good a point not to repeat. Supervision is not visitation. It is not helping this worker and this worker and this worker, though that is good. It is the planning, in advance, things to be done over a period of several weeks or several months.

The first thing to do is the inspection I have been talking about. Then, having inspected the situation, you make a list of all its needs. They may be deficiencies in the training of the workers, they may be new departures that should be injected, they may be corrections of procedures now being used. Whatever they are, make a long list. We pick out from that list, two, three, four or five (not more than four or five) major items and make them objectives. We may inspect a school and find that the children are below par in both speed and comprehension in arithmetic, speed in reading, or in both speed and knowledge. We have definite tests. A child in the fourth grade should be so good in speed. He should read so fast, and be able to comprehend completely a certain per cent of the material. We naturally test, and ordinarily children will be up to par if there isn't something the matter. You have to plan a

perfectly definite program to eliminate that difference, when they are found deficient. In another section you may find that a whole school of children is prone to use certain language errors. You have noticed in your own everyday experience that in certain localities certain language errors are common. Everybody uses them. At least there are certain deficiencies of grammatical construction.

In the old days we used to say: "We will give him more reading, give him more of the same." We don't do that any more in education. If a child can't read, we find out what is the matter. Very often it is the kind of book or choice of material. We diagnose the case (that should be a familiar word with you) and then we prescribe. And, by the way, that is the very term we use in the field of remedial teaching. After we have diagnosed the case, we plan a program for remedial teaching. You see what I mean. We find out the books that are useful and we prepare them in advance and talk about the material in the book. It is of no avail to hand out books and bulletins and then have everybody meet and talk about them, but we talk about them in advance of the bulletins. We have group meetings and so on. We do a great many things like that. We actually check back to see if we get it right.

The great difficulty of educational supervision has been until recently, I think, that we set up a grand program of supervision, issued bulletins, and read some books, and had lots of fuss. At the end of the year we checked up and found that some children are better, but that some are badly taught.

I remember a youngster who lived down on the shore where we were spending the summer. He played with me as a boy. We had great sport making a mark and shooting at it. He was a very much better shot than I was. It irritated me a great deal and was very annoying. I couldn't shoot as well as he did, until I got wise to his system. Then it was nip and tuck. His system was this: He always announced what he was shooting at, after he had shot.

In the school business we have a little of that, but not much. We have principals and superintendents who issue annual reports pointing out what they have done. It is much better to set up a supervisory program earlier in the year and say, "We are shooting at that," and then go back and inspect it and see how well you have progressed.

I have tried very briefly to present to you the four major functions of supervision, certain points of contrast between traditional and modern supervision, to investigate the necessity of a planned and organized program of supervision so that you can carry on continuous work with the people you are supervising throughout the period involved.

Supervision of Clinical Instruction[1]

MARY M. MARVIN, R.N.

THE first problem with which one is confronted in this discussion is that of defining the scope of clinical instruction. Is clinical teaching limited to the teaching which takes place in a hospital ward or does it also include the teaching of the nursing classes following the physician's lectures?

Supervisors of departments like the pediatric and surgical, who are familiar with the ward activities, ought to be the best prepared to teach the nursing classes related to these specialties. If these classes are well correlated with the work of the wards and are taught by the heads of the special departments, should clinical teaching not include the teaching of the clinical nursing subjects as well as the teaching in the ward? If this were done, there would be two distinct groups of clinical teachers, the supervisors and the head nurses.

To distinguish between these two positions, the definition stated in the 33rd report of the National League of Nursing Education will be used:

> In order that all should have the same meaning of the terms supervisor and head nurse, it was decided to call a graduate nurse who was responsible for two or more wards in care of charge nurses, a supervisor, whereas a graduate in charge of a smaller unit would be referred to as a head nurse.

There are many reasons for the prevailing interest in more systematic programs of ward teaching which it might be well to review at this point. First and foremost, the hospital wards, the laboratories of the nursing schools, are the only places in the world where students, through long continued practice, can learn the art of nursing. This in itself makes an adequate supervision of the practical work imperative.

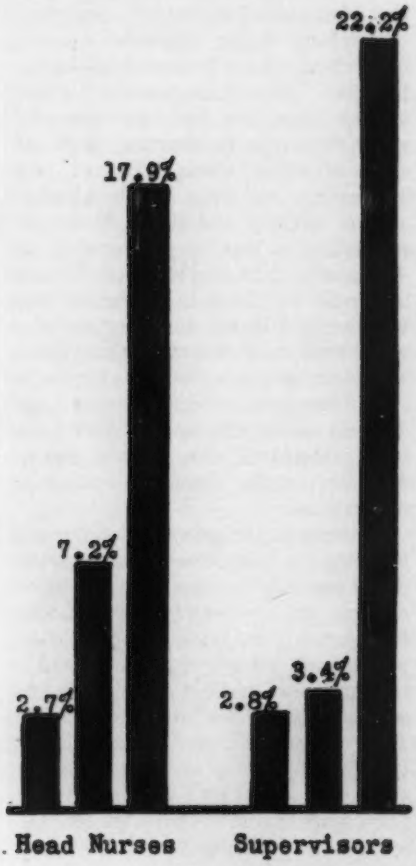
Another factor which has influenced the demand for better organized supervision is the increased amount of medical research carried on in the hospital. Numerous new cardiac and kidney tests, new hydrotherapy and psychotherapy treatments, and all sorts of other special medical procedures are evolving. Although physicians initiate and direct these experiments, it has been necessary to delegate an unlimited number of exacting tasks to nurses. Naturally this has resulted in the building up of a whole group of new nursing procedures which are necessary in carrying them out. The increased number and the delicate nature of many of these tests and procedures are making heavy demands on the time and energy of supervisors.

Along with the growth of American hospitals and the increase in the number of patients has come the admission of younger women to the schools. Because of this, a vigorous and competent type of supervision is needed in taking care of patients and providing satisfactory service to the physician. That is not all, however. During the period when immature undergraduates are forced to assume difficult and taxing responsibilities, the school is under obligation to give them protection.

Still another stimulating influence in improving supervision may be attributed to the better qualified administrators and teachers. They appreciate that the best results from classroom instruction can be brought about only through coördinated plans of ward teaching.

[1] Read at a general session of National League of Nursing Education, Milwaukee, Wis., June 13, 1930.

Time Spent by Head Nurses and Supervisors in Bedside Nursing. Low, average, and high percentages are shown.



To sum up: First, the adult education movement in the country; second, the fact that enormous numbers of young people find it possible and necessary to give themselves a college preparation; and third, the increase in the number of nursing organization meetings with stimulating programs in supervision, all have challenged the interest and fired the ambition of great numbers of supervisors and head nurses. For all these reasons, well planned programs of supervision are appearing in many places and have functioned long enough to prove that they are indispensable to the program of every modern school of nursing.

At this particular stage of our professional development, when we are experimenting with various phases of a new kind of supervision, it might be rather helpful to know just what an analysis of a week's work of several individuals shows about the jobs at the present time. To this end, one hundred nurses in these two positions were asked to keep diaries indicating all the professional activities participated in for one entire week. Of the one hundred special forms sent around the country, only twenty were returned that could be used for this purpose. These diaries represented the activities of eleven supervisors and nine head nurses for one week, which totalled one hundred forty days or a period of four and one-half months. It is regrettable that a larger number were unable to keep detailed records and do the work too. Is it not safe to assume that the results shown by this study representing a week's work of twenty individuals from good schools in different parts of the country are at least an index to the situation in many other schools?

The studies of the work of supervisors and head nurses were made separately although the same technic was followed for each. The steps taken in making the studies were as follows:

First, Separating each function listed on the diary from every other function by copying it on a piece of paper, stating the performance time, the date, and the name of the individual.

Second, Classifying the functions of each

individual by grouping separately all like functions for each day of the week and determining the time spent on each; for example, the amount of time spent in taking and giving reports on Monday, and finally, the amount of time spent in giving and taking reports all week.

Third, Adding the amount of time spent in the performance of each function for the whole group for a week; for example, the time spent by all head nurses or all supervisors in giving and taking reports for the week.

Fourth, Mathematically transposing the figures representing the time spent in each activity by each individual, so that figures for the whole group of head nurses or supervisors would be on the same basis for purposes of comparison.

Fifth, Making three calculations to show the percentage time of the individual who spent the least time, the one who spent the most time and, finally, the percentage time spent by the average of each group.

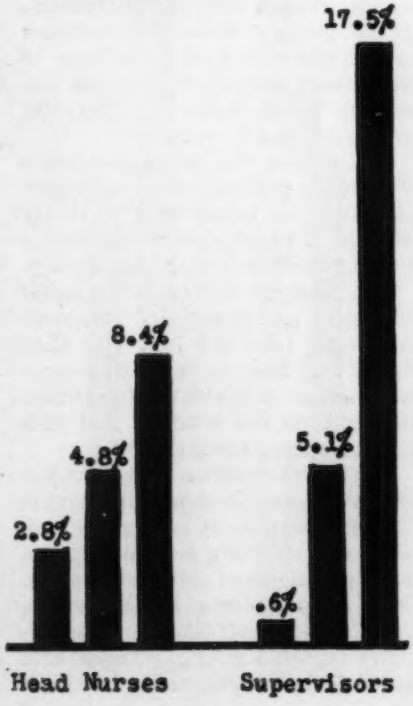
Sixth, Making graphs to show the results of each step described. The whole set of graphs will not be shown here. Those most pertinent to our problem will be discussed. They show the percentage time spent by each individual taking care of patients, housekeeping, teaching and supervising patients, and teaching and supervising nurses. Two other activities were added to these because of their special significance, the time spent in "rounds" by a supervisor and the time spent in "writing reports and requisitions" by head nurses.

The activity mentioned first was that of nursing patients. This consisted of giving baths and enemata, catheterizing, irrigating wounds, assisting with dressings, giving hypodermics and the like. If these duties are inconsistent with the work of the head of the ward, certainly they should not be expected to be performed by the head of a whole department. One supervisor spent 20 per cent of her time in nursing patients. It seems incredible that a supervisor in a modern school of nursing should be expected to spend over one-fifth of a whole week, that is over forty hours, actually giving nursing care to patients.

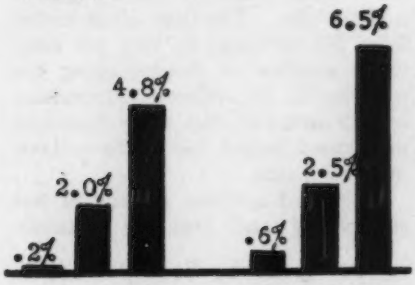
The next activity mentioned was housekeeping. It consisted of inspecting equipment, cleaning the office, taking inventories, supervising the cleaning done by maids and orderlies, checking up and ordering household supplies, setting up standards for various kinds of ward supplies, and the like. The time spent varied from 8.5 per cent to 17.5 per cent. Some aspects of housekeeping are essential in the efficient supervision of a department, but many functions mentioned might better have been done by maids.

The third activity mentioned was supervising and teaching patients.

Time Spent by Head Nurses and Supervisors in Housekeeping Duties. Low, average, and high percentages are shown.



Time Spent by Head Nurses and Supervisors in Teaching and Supervising Patients. Low, average and high percentages are shown.



The latter included instruction in matters related to diet, personal hygiene, home care and prevention. The time spent in teaching patients or in supervising the teaching of patients by students by any one person was almost negligible. The most time spent was 6.5 per cent.

One regrets the lost opportunities of teaching patients how to take care of themselves before they leave the institution which should represent a great health center of the community.

The teaching seemed to be rather incidental and superficial. Supervisors must take the lead and they should help head nurses initiate regular programs of health teaching which the students can conduct, and thus gain experience along that line.

The fourth function suggested was supervising and teaching pupil nurses. The teaching done by head nurses consisted of conducting morning reports, nursing clinics, and giving demonstrations of procedures in the wards. On the other hand, teaching by supervisors included giving instruction in the clinical subjects, such as the surgical nursing classes. Thus, in reality, most of the ward teaching was done by head nurses. The time spent in teaching ranged from an average of one-half hour per day on the part of one individual, .02 per cent, to over four hours per day on the part of another, 31 per cent. How interesting and enlightening it would have been to have known the quality of nursing care given to patients in those two situations. It is likely that well directed teaching in the ward is consistent with treatments given properly and on time, completely recorded as a result of intelligent observation of the reaction of the patient.

It is gratifying to know that in some cases the wards are really functioning as nursing laboratories where a teacher spends a third of a whole week guiding the activities of the students.

The fifth and sixth activities mentioned were concerned with the work of supervisors and head nurses taken separately. Rounds made by a supervisor seem plausible until one analyzes the day's work of the individual and finds that it does not include rounds with the physician nor rounds for the purpose of supervision of the student nurse's work. When the head of a whole department spends one-fifth of her time for an entire week in this way, one must challenge the structure of the supervisory plan that allows it.

One wonders what these trips called "rounds" amount to. Real supervision is such a different matter. It entails observation of the students' work, preferably in action. It consists of giving help and inspiration to the students, making the necessary constructive criticism, evaluating the work of each, estimating the progress made, et cetera. While this kind of work is only one aspect of the whole

supervisory program, on the other hand, it is in reality the whole heart of nursing supervision. It is the test of the technical, as well as the art side of supervision and calls for systematic planning in order that the supervisor may keep in close touch with the most crucial proceedings in her department.

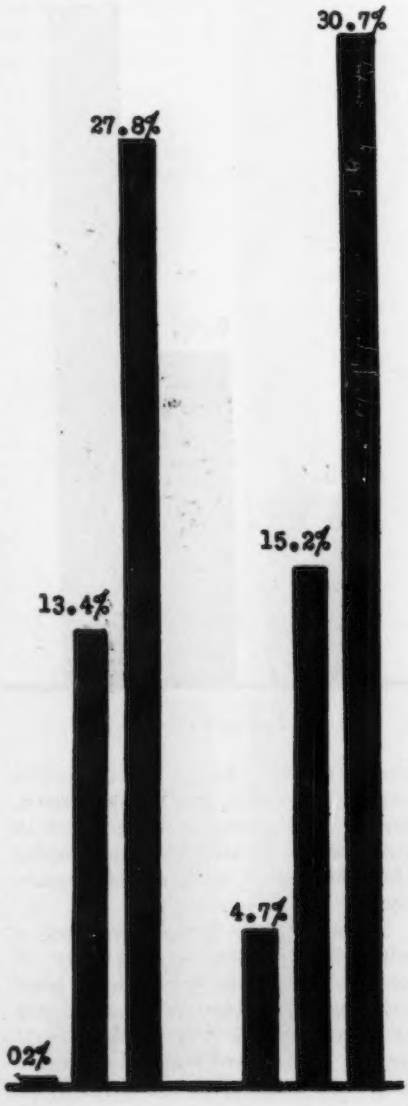
The last activity mentioned was reported upon by head nurses who spent from three and one-half hours in one instance, to thirty-five and one-half hours in another, writing reports and requisitions.

Two possible causes of this pernicious practice are: inefficient management on the part of head nurses who copy all sorts of daily sheets and books unnecessarily or, on the other hand, too much "red tape" on the part of a hospital that requires an inordinate amount of clerical work from a nursing staff. To correct this, mimeographed or printed sheets, such as those used for requisitions, inventories, time slips, assignments and treatment sheets would curtail much of the hand writing and, at the same time, conserve a great deal of time and energy which could be put to better use.

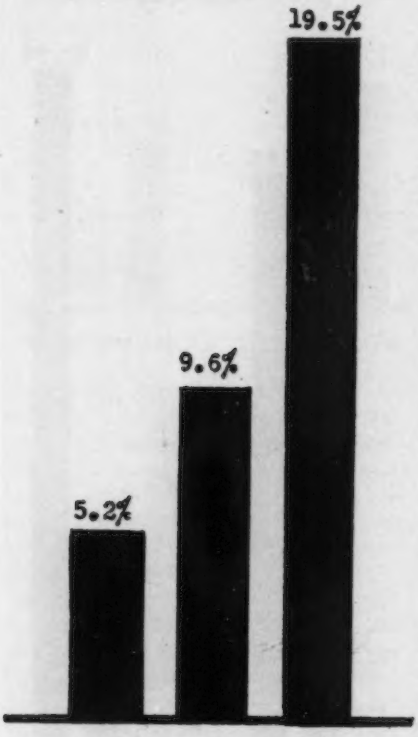
Altogether, this limited analysis reveals some interesting facts about these two positions. In certain instances, supervisors who were heads of departments, and head nurses in charge of wards, were doing practically identical work and the supervisors could not be said to be on a distinctly higher level.

It is disappointing to find so little difference in the time spent by the average of the two groups in the important functions of teaching and supervising student nurses. The average supervisor spent only 16 per cent of the week in teaching, whereas the average head nurse spent 14 per

Time Spent by Head Nurses and Supervisors in Teaching and Supervising Nurses. Low, average, and high percentages are shown.



Time Spent by Supervisors in Making "Rounds". Low, average, and high percentages are shown.



cent in the same way. It is natural to expect the older, more experienced, higher paid group of supervisors to take more responsibility in developing the educational work of the department.

Moreover, the assumption by a supervisor of the nursing care of patients is incompatible with the good management of a busy ward, much less the management of a whole department. There are several possible causes for the situation which existed in a few cases. The condition of under-staffing, which is hazardous for patients, compels head nurses and supervisors to give personal nursing care to the patients. Poor management in arranging the work may be another cause, although it does not seem as though this could account altogether for the situation. Finally, the week chosen for recording the activities may have been an irregular or an emergency week. The latter situation seems unlikely inasmuch as this was not stated by anyone keeping a diary. In the case of each group the time spent by the average individual in nursing patients ranged from three and one-half to six hours per week. Surely it must be a matter of deep concern to the principal of the school that these members of her staff have to spend so much of their time doing other people's work.

The function of teaching patients was nil in many cases, whereas supervising patients was most inadequate in others. Flying trips through wards of a department can scarcely amount to more than a superficial inspection and it cannot be considered supervision of patients and nurses.

One of the most outstanding characteristics of the whole study is the great discrepancy between the way in which the individuals of the same group spend their time. In one case there was nineteen and one-half hours' difference in the time spent by two head nurses doing the same thing. Why was this? Do head nurses interpret their jobs differently? Do supervisors? If one person spends an enormous amount of time writing reports, while another finds much time for teaching nurses, the two individuals must interpret their positions very differently. It must be seen that the new head-nurse applicant has the right conception of her responsibilities

before she is accepted for the position. She must realize her new duties are to be housekeeping, nursing and management, as well as teaching.

To summarize briefly, the analysis shows that the first plank in the program of supervision is the analysis, study, and reorganization of the work of both positions in order that there shall be two groups of workers on two distinct levels, one the head-nurse level, the other the supervisory.

In many schools earnest efforts are being made to improve the supervision fundamentally. Some of the most important ones are:

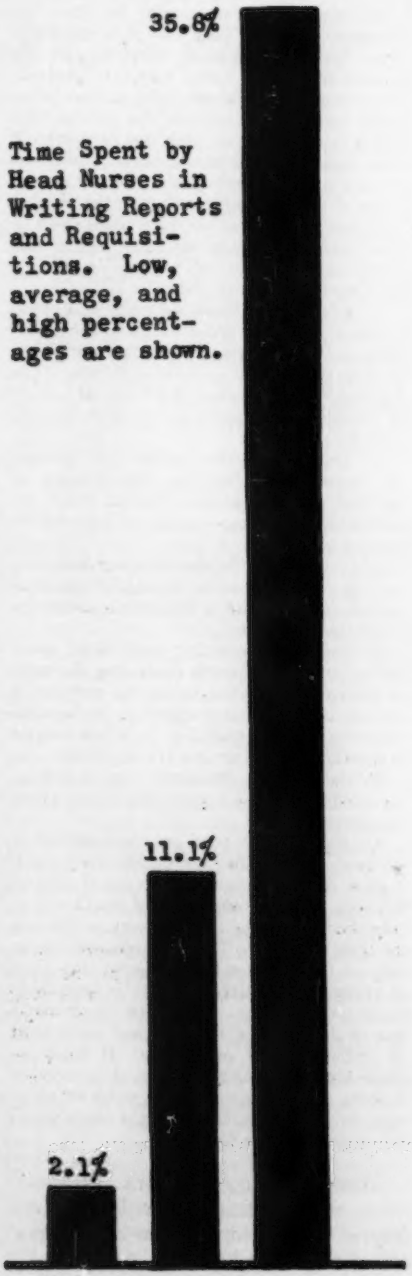
First, The employment of a sufficient number of graduate nurses to ensure good nursing in the hospital. This is basic.

Second, Arrangement of programs of staff education for the general duty group, to make them more valuable to the hospital employing them, and at the same time to make them happier by offering them an opportunity for personal and professional growth.

Third, Giving supervisors an opportunity to help in the selection of new members of their immediate staff.

Fourth, Developing further the "in-service" programs in preparation of head nurses, inasmuch as most of them cannot secure previous training. These programs may include special plans for the introduction of new head nurses to the wards, similar to those now used for students. There would be several advantages in this kind of a plan. The new head nurse would know what was expected of her at the start; she would have time to learn many of her responsibilities before actually having to assume them; the students would not suffer a loss in their experience during the interval when head nurses were changing; and, finally, the newcomer could learn something of the larger plan of the whole department rather than just the detached plan for her own individual ward.

Fifth, Encouraging supervisors to equip themselves and giving them time to assist with or direct special important departmental studies. Careful studies must be made to throw light on problems which now stand in the way of progress in supervision. Because of the tremendous importance of getting at these studies soon, a few of the more pressing ones will be mentioned here:



Time Spent by Head Nurses in Writing Reports and Requisitions. Low, average, and high percentages are shown.

(a) Making studies similar to those by Margaret Tracy of Yale, Gladys Sellew of the Cook County School of Nursing, and the present cost study under way in Cleveland. These studies will throw light on the factor which very nearly controls the success with which any supervisory plan can be operated. The number of nurses needed in different services at all seasons of the year, at special hours of the day, compared with the number of nurses provided at all these times must be faced squarely before anything like a real educational program of supervision can be developed and maintained.

(b) Finding out what the traits and qualifications are which are essential to the supervisor and head nurse in accordance with the modern conception of these positions. The Education Committee of the National League of Nursing Education is now at work on such a study.

(c) Determining the limitation of the size of departments, that is, the number of patients, head nurses, and students which one individual supervisor should be expected to manage efficiently.

(d) Estimating the size of a ward or floor for which a head nurse should be expected to be responsible with or without the assistance of another graduate.

(e) Developing a rating scale which could be used by supervisors in evaluating the work of individual head nurses for the purpose of stimulating their growth as well as for the identification of those qualities which are needed in positions of still greater responsibility.

(f) Determining standards for evaluating the adequacy of the supervision of any given department.

(g) Arriving at a good practical method of evaluating the quality of nursing care. Such a scale is much needed by scores of clinical teachers. They want a set of standards to help them judge the nursing work of the day for their patients. This measurement would help us to detect and provide the only kind of nursing care which ought to be acceptable in our schools today. It must be the all-round care which implies a great deal more skill in performance of procedures. It must include the proper consideration of preventive aspects, health teaching, but most of all it must involve an understanding of the individual patient and his needs.

These are only a few of the problems which compel our interest in improving the supervision in this new era of nursing education.

Work of National Leprosarium During Past Fiscal Year

A REPORT recently submitted indicates that during the last fiscal year at the National Home for Lepers maintained by the Public Health Service at Carville, La., forty-nine new patients were admitted. There was an average of slightly more than 300 patients in the institution during the year. It is encouraging to note that nineteen patients were released as no longer a menace to the public health. Six additional patients complied with the requirements for parole but, owing to their deformities and disfigurements which could not be cured, these patients elected to remain in the hospital rather than be subjected to the hardships and humiliations which are frequently the portion of many paroled lepers.

The nativity of the various patients of the leprosarium indicates that Louisiana and Florida had the largest number of any of the states; there were ten patients who were born in Ohio. Of the patients admitted during the year, California leads with fifteen, Louisiana follows next with eleven, Texas with six, and Florida with five.

Chaulmoogra oil, by mouth, was used as routine treatment for 137 patients, the dosage ranging from 9 to 375 drops daily. One hundred and eighty patients are taking hypodermic injections of a special derivative of chaulmoogra oil. Dental work has been continued, as necessary. Supplementary treatment by means of physiotherapy and special light treatments are also given.—From *Health News* of the U. S. Public Health Service.

A CORRECTION—In the June *Journal*, page 739, a mistake was made in referring to Miss Titus as having held the office of President of the Michigan State Nurses' Association. Miss Titus asks that this be corrected, as she has not held that office.

California To Require High School Graduation

THE California Board of Health at its monthly meeting, June 7, 1930, voted to raise the preliminary education admission requirements to schools of nursing from one year of high school to high school graduation or an educational equivalent, this to become effective January 1, 1931.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Around the World with the Red Cross Nurse

FROM Elsie Jessup Waring, American Red Cross nurse, Lagos, Nigeria, B. W. Africa, whose husband is connected with the Nigerian Railroad, we received the following interesting story:

Last year, while in the "bush" with my husband, I had a nursing experience which I thought might be of interest to you. We were about 150 miles from the nearest hospital or doctor when a violent epidemic of influenza broke out in the native town of about 3,000. It was in the country of the Emir (or Mohammedan) rulers and, as you know, their idea of women is not a high one. My first patients were workmen of my husband's, who were sent to me by him for medicine. I had nothing on hand but Epsom salt and iodin, but sent an s.o.s. to the hospital, and they very generously supplied me with Stokes' mixture and liquid quinine, within a few days. Our bungalow consisted of two rooms and a large verandah, and the latter became my impromptu dispensary. Every morning there were between fifteen and twenty natives squatting on the floor, coughing, waiting for the "Missus" to help them. Also wives and babies eventually came, after they found that the strange white woman had helped the men.

One day my house boy ran to me in the bungalow in great excitement and said, "The King he come, Ma." I looked out and there was the Emir himself, dismounting from a beautiful stallion, preceded by men blowing long trumpets and followed by members of his retinue, all clad in flowing robes with silk scarves wound about their turbans. The Emir came to the verandah on foot and, when he saw me, he knelt and touched his head to the ground three times; his three chief men did the same. They remained squatting while the Emir told me that he was ill, also his "prime minister" and would I help them? The only bottles I had to put their medicine in were a couple of empty beer bottles, but that did not seem to worry him at all. He passed them over to one of his followers to carry and, after many salutations and thanks, the party moved off, mounted their horses, and disappeared in a cloud of dust. A few days later, the same crowd appeared, and the old Emir came in to thank me for his recovery. The Political Officer of the District said it was almost the first time a Mohammedan African Chief had applied for help to a woman, so I felt duly proud, especially as I was American! This happened in Northern Nigeria at a place called Kafanchan.

A later letter tells of life at Lagos:

My husband is at present stationed in Lagos, and the medical department is capable of handling their "end" without my poor volunteer assistance, although there is a child welfare center opened and I'd love to get into the middle of that, if they would allow it.

The Rockefeller Commission has a very extensive group of doctors here, doing research for yellow fever. Dr. Beuwkes is in charge and is very popular with all the British residents as well as his own people (Americans).

At present, a few miles from Lagos there is a pest of locusts destroying the vegetation and, in some places, the entire population has been ordered out to dig trenches and burn the young ones as they hop along. Motoring a few days ago, we came to a part of the road which was black with the young locusts, all jumping about like grasshoppers. Unless the young ones can be destroyed, there will be a serious shortage of crops this year. The farmers lead a hand-to-mouth sort of existence at the best of times, so we are all praying that nothing will happen to make their crops fail entirely.

Lady Thomson, our Governor's wife, has started "The Ladies League of Nigeria" and a number of European women are trying to teach the native women and girls to sew. (It is an unwritten law that we never allude to ourselves as white and the others as black. It is always European or native.)

I am teaching two of these classes a week and Lady Thomson has asked me to give some lectures on hygiene to the girls. She is very

anxious to get hold of some magic lantern slides dealing with home hygiene, cleanliness, etc., and I thought perhaps you might be able to let me have an idea of how your A. R. C. nurses managed in some of their work in the districts down south. The native girls and women we deal with have the mentality of ten-year-old white children, so any group of slides which are used in elementary schools would be right for them.

Needless to say every effort will be made to comply with Mrs. Waring's request.

Alice Carr, American Red Cross nurse, writing from Athens, speaks of Miss Messolora, who visited the United States last summer. She will be pleasantly remembered by her many American nurse friends:

This time I have something really important to say to you. It concerns the awakening of the nursing world here and it strikes me that, after a long sound sleep, there will be considerable energy to spend and some excellent thinking. The Greek mind is a clear one, unmercifully unsentimental, but is capable of great accomplishment. It is an artistic one also and always wishes to do things supremely well or not at all.

The Greek Red Cross here is getting into something really beautiful, big, and basic. Their new hospital is a perfect thing of its kind and makes me proud. Each day I pass it on my way home. The new nurses' home is a splendid place. It was dedicated recently and is now occupied. The dedication ceremonies were most impressive. All the pupils and graduates were massed in front of the building in the sunshine, all the famous people of Greece were there and it certainly made a very impressive picture as the Archbishop, in his rich colorful robes, and other dignitaries spoke of the work and struggle of the past and rosy hopes of the future. Without doubt, this gathering of fine people under the blue Greek sky marks a time when science is going to step in and help solve the awful problems of this country's health.

Only recently I have met Miss Messolora. I have never really worked in Athens before and have always just missed her. Just now I have turned over to her my nursing class, having equipped them beautifully and subsidized them for the term of their training.

Our hospital in Syra (Near East Relief) this fall was almost empty and no longer will serve as a laboratory for training, so something had to be done. We are at the end of our orphanage program, so I had to look around for some native project to use and help. The Red Cross presented its need of pupils at the psychological moment, so we combined forces. All this is set forth almost verbatim in the enclosed report of the proceeding. I am very proud of our little girls. I know that they are going to do well and I feel that in contributing to this school we have done one of the best pieces of work that we have ever done. I wish it could have been a larger number, but last year our class was cut down from fifty to thirteen, on account of the emptying of the orphanage. There was no help for that.

Miss Messolora wishes to be most kindly remembered to you. I have never seen anybody so impressed as she is with the nursing work in America and the schools and hospitals. It is amazing. She wants her new hospital to combine all the good points of them all, and to have her nurses the highly capable and trustworthy women we have at home.

Just now I am in the throes of trying to get translated and printed in Greek the American Red Cross textbook, *Home Hygiene and Care of the Sick*. This I will put into classes in the camps where people are woefully in need of just such knowledge, because they not only have to fight poverty, but crowded conditions, dust storms, and mud, and all the thousand ills that such living brings. . . . I know that the American Red Cross has done marvelous things for the Red Cross here, and it is extremely wise and merciful in doing so. There never was a gift better placed.

Miss Carr also tells of many other interesting people, places and projects.

From Bilaspur, India, Caroline E. Pope, American Red Cross nurse, writes of her busy life and many interests from which we cull the following bits:

Judging from the number of obstetrical cases, the population of Bilaspur is on the gain. Our speed record is four cases in thirty-six hours. It has been much easier to encourage the Mohammedan and poorer Hindu women to take advantage of hospital care, but the well-to-do and high-caste Hindus have been hard to persuade. There is so much superstition, religious and otherwise, involved at

such a time. However, during the past year among our patients have been numbered the wife of a prominent lawyer, head of the Hindu Sabha, the wife and also the sister of one of our private practitioners, the wife of a government medical officer, who was on tour but left word that his wife was to go to the Mission Hospital, and many others.

As our nurses are required to care for twenty cases before they are eligible to sit for their midwifery examination, we are not only rendering a real service to many women in their time of need, but during the past year it has not been necessary to send any nurse away to complete her number of cases as was formerly required.

Ida Lusk Rohrer, a graduate of Bellevue Hospital School of Nursing, and a member of the Red Cross Nursing Service, writing from the Brent Hospital, Zamboanga, Philippine Islands, of which she is Superintendent, sends an interesting account of the hospital. Mrs. Rohrer's husband is a representative of the Standard Oil Company at Zamboanga. The hospital being without a superintendent, she consented to assume temporarily the responsibility of this office. She has found it impossible to leave. We quote the following extract:

Zamboanga is the capital of the Province of Zamboanga and is the flourishing port for the whole southern portion of Mindanao. It has a population of about 20,000.

This small city is noted all over the Philippines for beauty and progressiveness. On the outskirts of the town on the boulevard known as Kawa Kawa and in a large cocoanut grove directly overlooking the sea, is situated the Brent Hospital. Though a wooden structure throughout, it is excellently constructed of the very best native materials. The lower floor consists of offices, dispensary, and three well ventilated rooms, set apart respectively for the men's, women's, and children's wards. The entire upper floor is given over to the operating suite and private rooms. Referring to Dr. Baker, the hospital's first physician, we find that the then Zamboanga Hospital (it has been re-named since Bishop Brent's death) was formally opened February 7, 1914, and that the ceremonies were conducted by Bishop Brent. In the addresses by different people it was especially emphasized that the animating spirit of the hospital was essentially humanitarian, and its purpose was to minister to the sick and suffering of every race, sect, and creed. These assurances, then made, have been strictly adhered to and are as true today as when made years ago.

In spite of the fact that the hospital has been handicapped by too frequent changes of personnel, it still remains true that valiant service has been performed for all sorts and conditions of men. At present the hospital has a resident Filipino physician, graduate of an American College. There are also six graduate nurses from Manila, and much is being done to bring the hospital service up to a high standard. (The six nurses are natives trained under Americans.)

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Celia Evinger; Mrs. J. Faegin, née Gladys Marie Hamilton; Hazel Agnes Falls; Oliver Mary Falls; Katherine Farr; Ina Luella Faurot; Emma Ferguson; Jean Clark Ferguson; Alice Edna Fidiam; Mrs. Henry Fink, née Bertha Louise Wheeler; Carrie R. Fisher; Marion Flint; Mrs. Margaret T. Foley, née Halloran; Floyde Ellerslye Foreman; Mabel Ruth Fountaine; Mrs. J. W. Fountaine, née Vanette Irene Miller; Gladys B. Fowkes; Esther Fraux; Elizabeth B. Friedman; Mrs. H. D. Friend, née Erba Ann Dillman; Flossie Belle Frost; Mrs. Corinne Royal Fryre, née Smith; Mrs. J. B. Gibbons, née Lois Lillian Larive; Artiemichie Gintz; Sophronia H. Glover; Mrs. Athalinda Marguerte Glendening, née Cimmer; Mrs. J. D. Glunt, née Katherine Lucy Murphy; Mrs. Vella Louise Goodman, née Edwards; Mrs. S. S. Gordon, née Reba Shaeffer; Mrs. Richard C. Gorrie, née Agnes Josephine Olson; Belle Margaret Granger; Frances Jane Green; Mary Green; Mrs. Helen Angela Greenia, née Rivard; Mrs. Allen S. Gnew, née Elizabeth A. Nyhan.

Our Contributors

Our leading article demonstrates the high quality of **Anna L. Gibson's** work, although the subject is "a tremendous one and difficult to write about in non-technical language."

Burton J. Lee, M.D., is Clinical Director of the Memorial Hospital, New York City. (See "Nursing Care of Cancer Cases" in July *Journal*.)

The article by **Florence K. Root,** who is Dean of Women, Wooster College, Wooster, Ohio, is timely and should be helpful to directors of schools of nursing.

The timely article, "Two Common Diseases of the Skin of the Feet," is a fine example of coöperation between an office nurse and her "chief." **Mrs. Florence B. Biase, R.N.** (Army School of Nursing) is employed by **Dr. H. H. Hazen,** a specialist of Washington, D. C.

Ella M. Rafuse, R.N., M.A. (Children's Hospital, Boston, and Teachers College, New York) has had a varied experience, including that of visiting instructor.

Stanley Dorsey is the registered pharmacist at the Christian R. Holmes Hospital, Cincinnati, Ohio.

E. I. Erickson is the efficient and sympathetic Superintendent of the Augustana Hospital, Chicago, Ill.

Frances M. Heinrich, R.N. (Augustana Hospital School of Nursing) is and has for several years been a private duty nurse. She has a rich background of experience in both institutional and public health nursing.

Mary Margaret Muckley, R.N., is the dynamic executive of the Minneapolis Official Registry. (See "How One Registry Handles Its Work" in the January *Journal*.)

Lena M. Schmitt, R.N. (Ford Hospital School of Nursing and Hygiene) is a private duty nurse. Mrs. Schmitt is Chairman of the Private Duty Section of the District, and is a member of the Board of Directors of the Official Registry, Detroit.

Geneva A. Peters, R.N., is a private duty nurse who takes an active and constructive part in professional activities in Louisiana.

J. Beatrice Bowman, R.N., Superintendent of the Navy Nurse Corps, knew that all nurses would rejoice over the "step in advance" she describes.

Eleanor Helm, R.N. (Kahler Hospitals School of Nursing) is doing group nursing at the Kahler Hospital, Rochester, Minn.

Hester Viney, S.R.N. (See April *Journal*) was a lecturer at the College of Nursing, London, when she prepared the article on British registration for us.

We are indebted to **Daisy Dean Urch, R.N., M.A.,** the able Director of the School of Nursing at Highland Hospital, Oakland, Calif., for transmitting "An Ambulance Emergency Kit," written by **Margaret Peters.**

John Lapp, Ph.D., Professor of Sociology at Marquette University and an unusually interesting and able speaker, held the intense interest of a huge audience at Milwaukee, when he spoke on "Insurance for Professional People."

Emilie Sargent, R.N., B.A., is Superintendent of the Visiting Nurse Association, Detroit, and is the President of the Michigan State Nurses' Association, which has been studying the problem of insurance for nurses.

Because many nurses have wondered "how the Grading Committee spends its money," we asked **Dr. Burgess** to describe the actual work of her office. However, nothing but a visual image of that staff, working elbow to elbow, really tells the story of intense activity.

Myra B. Conover, R.N., A.B., is Superintendent of the New York Skin and Cancer Hospital. Her own unusually fine training and experience eminently fit her to appreciate Miss Gibson's work.

The paper by **Dr. W. H. Burton,** Professor of Education, University of Chicago, was described at Milwaukee as "worth travelling to the Convention to hear." That paper and **Mary M. Marvin's** "Supervision of Clinical Instruction" we believe are destined to become classics in our literature on that exceedingly important subject. No nurse administrator, whether in hospital, school, or public health, can afford not to put them aside for careful reading.

Margaret Norris, R.N., is Operating Room Supervisor at the Akron City Hospital, Akron, Ohio.

Student Nurses' Page

Anatomical Correlation Study

WILNA SLAPAK

Cook County Hospital School of Nursing, Chicago, Ill.

(This is one of the studies made after the completion of the anatomy class work and after students are assigned to full time duty (third quarter) on the wards. It is an example of correlation of theory, as taught in the classroom, with practice as found on the wards, under the direction of Ella Best, Instructor in Anatomy and Physiology.—EDITOR.)

REGION INVOLVED	CONDITION OBSERVED	OUTSTANDING TREATMENT
I. *Lower Extremity*		
1. Foot	a. Dry diabetic gangrene of little toe, left foot.	a. Amputation of toe, dry dressings.
	b. Dry gangrene of left foot with progress to knee, probably arteriosclerotic.	b. Ligation of femoral artery, to allow self-amputation.
2. Fibula	a. Fracture of lower third of fibula.	a. Posterior molded splint, bed rest for a few days.
3. Fibula and tibia	a. Tuberculosis involving tibia and fibula of left leg. Incurable.	a. Bed rest.
4. Patella	a. Fracture.	a. X-ray, cast, complete rest.
	b. Arthritis deformans involving knee joint and bones above and below.	b. Bed rest, cast, medications.
5. Femur	a. Fracture of lower third.	a. Cast, sand bags. Later use of crutches and caliper.
	b. Fracture of neck of femur.	b. Sand bags. No cast because injury irreparable—patient 92 years old.
	c. Fracture of neck of femur.	c. Reduction. Extension with weights.
	d. Contusion over right trochanter.	d. Dakin's dressings.
6. Fascia of lateral surface of thigh	a. Cellulitis with ulcer.	a. Continuous hot dressings, Dakin's irrigations of wound.
7. Dorsal surface of thigh	a. Cold abscess, suspected Pott's disease.	a. Incision and drainage.
8. Muscles and tendons	a. Infected dog bites of tendon or right gastrocnemius muscle.	a. Antirabies serum, Dakin's irrigation to open wound, cast to maintain position.
	b. Infected dog bites of Achilles tendon of right foot.	b. Antirabies serum, Dakin's irrigation to wound, sodium bicarbonate tubbings.
9. Veins	a. Phlebitis with edematous congestion of leg and thigh.	a. Elevation of extremity on pillows, continuous light cradle.
	b. Varicose ulcer.	b. Unna's boot.

Region Involved	Condition Observed	Outstanding Treatment
10. Arteries	a. Arteriosclerotic wet gangrene of foot.	a. Ligation of femoral artery and vein, to change a wet gangrene to dry gangrene, thereby preventing infection along line of demarcation and making possible an elective amputation.
11. Sciatic sheath	a. Lipoma, dorsal surface of thigh.	a. Romoval of lipoma.
12. Foreign body in thigh	a. Gunshot wound on medial surface of thigh, bullet remaining under skin of lateral surface. No injury to femur.	a. Dressings to wound. Bullet left in place.
II. *Upper Extremity*		
1. Hand	a. Needle in fascia of palm.	a. Removal of needle, suturing of area.
	b. Osteomyelitis with open infection of right index finger, subsequent loss of nail, paronychia.	b. Incision and drainage, hot dressings, hot boric soaks.
	c. Infection with osteomyelitis of dorsal aspect of first phalanx of fourth finger, right hand.	c. X-ray, hot dressings, incision and drainage.
	d. Congenital fusion of middle and fourth fingers of both hands, syndactylism.	d. Operative separation of phalanges.
	e. Infection of fifth finger with involvement of axillary lymph glands and general toxemia.	e. Continuous hot wet dressings, light cradle, medications for temperature. Later hot boric soaks to hand.
2. Wrist	a. Colles' fracture of distal end of radius.	a. Plaster cast applied.
3. Forearm, volar surface near middle of ulna	a. Contusion with open abrasion.	a. Rest to part, dry dressings.
4. Cubital fossa, median basilic vein	a. Hypertension of nephritis.	a. Venesection, withdrawal of 500 cc. of blood.
5. Biceps muscle	a. Bite upon median surface, subsequent regional infection.	a. Dakin's irrigation.
6. Elbow	a. Abrasion of olecranon process.	a. Rest to arm.
	b. Intense shooting pain, evidently beginning osteomyelitis.	b. Awaiting x-ray and further clinical findings. Continuous hot dressings.
7. Surgical neck of right humerus	a. Fracture.	a. Placed in extension.
8. Entire forearm and arm	a. Edema of right arm involving axillary lymphatics.	a. Elevation upon pillow.
	b. First degree burns of skin of forearm, and arm on dorsal surface and axillary region.	b. Sodium bicarbonate tubbing, adhesive strips, and vaseline strips, exercise with weights to maintain muscle function and prevent contractures.
III. *Head and Neck*		
1. Bones of head		
A. Temporal bone	a. Acute purulent otitis media.	a. Bed rest, medication, hot water bottle, p.r.n.
	b. Mastoiditis, with drainage from ear.	b. Hot dressings.
B. Frontal bone Cerebral cortex	a. Fracture with depression on left side resulting in traumatic psychosis and right lower facial paralysis.	a. Bed rest.

Region Involved	Condition Observed	Outstanding Treatment
	b. Fracture.	b. Suturing of abraded area, treatment for shock.
C. Mandible	a. Suspected fracture.	a. X-ray, wiring of bone.
D. Maxilla		
Right maxillary sinus	a. Sinusitis as a result of acute coryza.	a. Drainage.
2. Skin and fascia of head and neck		
A. Skin of face	a. First degree burns with bleb formation and infection of eyes.	a. Vaseline and olive oil to skin, boric eye irrigations.
B. Eyelids	a. Edema of both eyelids following empyema and myocarditis.	a. Limited fluids, bed rest, systemic medication.
C. Dorsal surface left side of neck	a. Cervical abscess.	a. Incision and drainage. Hot dressings.
	b. Diabetic cellulitis.	b. Incision and drainage.
3. Tonsillar region	a. Malignant tonsillar hypertrophy.	a. Bed rest, morphine sulphate, p.r.n.
4. Trachea	a. Carcinoma of trachea and lymph glands of neck.	a. Bed rest, morphine sulphate, p.r.n.
5. Thyroid gland	a. Exophthalmic goitre—one month.	a. Thyroidectomy, Lugol's solution.
	b. Exophthalmic goitre—twenty years, with growth beneath clavicle and middle of sternum.	b. Thyroidectomy, Lugol's solution.
6. Brain and appendages	a. Inflammation of ganglionated roots of trigeminal nerve.	a. Morphine, ice bag, subsequent surgical procedure.
	b. Parkinsonism as sequel to encephalitis.	b. Scopolamin as specific.
	c. Meningitis.	c. Isolation, symptomatic treatment.
IV. *Trunk*		
1. Pelvis		
A. Rectum	a. Tightening of levator ani and external sphincter muscles, due to hemorrhoidectomy.	a. Dilatation of anus.
	b. Carcinoma of rectum.	b. Operative procedure, suppositories.
B. Reproductive organs	a. Salpingitis, fibroid tumors between rectum and uterus, and between uterus and bladder.	a. Panhysterectomy, excision of fibroid tumors.
	b. Vesicovaginal fistula.	b. Operative repair.
	c. Bilateral salpingitis with infection of ovaries.	c. Bilateral salpingectomy with oöphorectomy.
	d. Ectopic pregnancy.	d. Right salpingectomy.
C. Bladder	a. Cystitis (gonorrheal).	a. Medications.
	b. Gunshot wounds puncturing wall in two places, from ventral surface.	b. Insertion of tube for urinary drainage, dressings.
2. Abdomen		
A. Appendix	a. Interval appendicitis.	a. Bed rest, ice bag to side.
	b. Appendiceal abscess.	b. Drainage, hot dressings.
	c. Ruptured appendix.	c. Emergency appendectomy.
	d. Chronic appendicitis.	d. Appendectomy.
B. Small intestine	a. Fecal fistula.	a. Drainage. Attempt to close by skin graft and ultraviolet stimulation.
	b. Partial intestinal obstruction due to carcinoma of ileum, with intense vomiting of fecal matter.	b. Fluids by mouth and hypodermoclysis.
	c. Carcinoma of jejunum.	c. Jejunostomy.
	d. Carcinoma of pyloric valve.	d. Gastro-enterostomy.

Region Involved	Condition Observed	Outstanding Treatment
C. Liver	a. Catarrhal jaundice.	a. Medications.
	b. Atrophic cirrhosis of liver.	b. Bed rest, milk diet.
	c. Metastasis of carcimona of the breast to liver with enlargement and nodule formation.	c. Inoperable, bed rest.
D. Gall bladder	a. Cholecystitis with cholelithiasis.	a. Cholecystectomy.
	b. Rupture of gall bladder.	b. Drainage.
E. Pancreas	a. Diabetes mellitus.	a. Insulin, special diet, rest.
F. Stomach	a. Carcinoma of lesser curvature, with abnormal peristaltic action, gastric disturbance.	a. Gastro-enterostomy, special postoperative diet.
G. Spleen	a. Rupture.	a. Blood transfusion, treat for shock in reverse Fowler's position.
H. Kidneys and bladder	a. Chronic nephritis with hypertension, edema.	a. Bed rest, salt-free diet, limited fluids, venesection.
	b. Nephrosis with cardiac decompensation.	b. Same as (a).
	c. Renal calculus.	c. Bedrest, medications.
	d. Pyelitis.	d. Push fluids, bed rest, medications.
3. Abdominal wall	a. Ventral hernia.	a. Herniotomy.
	b. Umbilical hernia.	b. Herniotomy.
	c. Postoperative hernia of fifteen years' duration following appendectomy, ectopic pregnancy.	c. Herniotomy, salpingectomy.
	d. Inguinal hernia.	d. Herniotomy, Dakin's irrigation.
	e. Adhesions in umbilical region.	e. Bed rest.
	f. Foreign body, three-inch nail, in old abdominal incision. (Patient, dementia praecox, could not remember placing nail in side.)	f. Excision of foreign body.
	g. Tuberculous abscess.	g. Incision and drainage, hot dressings.
	h. Abdominal lacerations from knife wounds.	h. Suturing.
4. Thorax		
A. Lungs and pleura	a. Pleurisy with effusion, following pneumonia.	a. Rib resection, removal of fluid from cavity. Dakin's irrigations.
	b. Empyema following pneumonia, with edema in extremities from endocarditis.	b. Drainage, dry dressings, p.r.n.
	c. Adhesions.	c. Bed rest.
	d. Lung abscess.	d. Medications, serum administration.
B. Heart	a. Endocarditis with edema, following pneumonia.	a. Medications, ice bag.
	b. Hypertensive heart disease with emphysema and polycythemia.	b. Absolute rest in bed, medications.
	c. Left ventricular hypertrophy.	c. Absolute bed rest, medications.
	d. Myocarditis with arteriosclerosis.	d. Absolute bed rest, medications.
	e. Luetic heart disease with aneurysmal dilatation.	e. Same as above.
C. Breast	a. Carcinoma of right breast with metastasis to liver and progressive jaundice	a. Bed rest, inoperable.

Region Involved	Condition Observed	Outstanding Treatment
	b. Carcinoma of left breast with involvement of cervical and axillary lymphatics and edema of left arm.	b. Bed rest, vaseline strips and Dakin's dressings to area, inoperable.
	c. Carcinoma of breast.	c. Radical breast amputation.
	d. Chronic tuberculous mastitis.	d. Incision and drainage, Dakin's irrigation, hot dressings.
	e. Breast abscess.	e. Incision and drainage, hot dressings.
V. *Miscellaneous Systemic*	Bacterial	
A. Joints	a. Acute rheumatic fever.	a. Absolute bed rest, quiet, medications.
B. Neuro-muscular unit	a. Syphilis with resultant locomotor ataxia.	a. Specific treatment, mercurial inunctions, neosalvarsan, potassium iodide.
C. Intestine	Parasitic a. Amoebic dysentery.	a. Isolation, specific medication, quinine bisulphate enema, emetine subcutaneously.
D. Blood vascular	a. Pernicious anemia.	a. Medication, dessicated mucosa pig's stomach. Vitamin high diet.
E. Nerves	a. Arteriosclerotic dementia.	a. Institutional care.
	b. Acute arsenical polyneuritis, involvement of peripheral nerves.	b. Medication to rid body of arsenic.
	c. Huntington's chorea.	c. Institutional care.
	d. Acute alcoholic polyneuritis.	d. Paraldehyde, "D.T." mixture.
	e. Tumor at filum terminale, with anaesthesia of portions of gluteal region and loss of bladder and rectal control.	e. Surgical procedure.

Bureau of Nursing Service

District No. 5, California State Nurses' Association

IN 1927 we responded to calls amounting to 15,071, in 1928 we responded to calls amounting to 20,760, in 1929 we responded to calls amounting to 27,736.

This year we have made an effort to study the oversupply of nurses in Los Angeles. (I may say that for 1927 and 1928, only the cards of nurses still with us were studied.) A survey of our cards shows that in 1927, 236 nurses averaged 56½ days each, on call, or a total of 13,316 nursing days in excess of the need; in 1928, 475 nurses averaged 33 1/7 days each, on call, or a total of 14,575 nursing days in excess of the need; in 1929, 899 nurses averaged 39 1/7 days each, on call, or a total of 35,182 nursing days in excess of the need. This actually means one nurse over a period of ninety-six years. Surely we should heed these figures and urge a remedy of this situation. Your office has made every effort to impress the nurses who come to Los Angeles from other schools, with the situation.

In studying the cards, it was revealed that the age of the nurse seemed to have little to do with her ability to satisfactorily respond to a call. This unquestionably rests with the personality and competence of the nurse. The greatest number of days on call by any one member was 246 days in 1929. This member graduated in 1925—refused the following types of illness, tuberculosis, communicable, mental, out of the city; she refused to nurse in two hospitals, and four hospitals refused her permission to nurse in their institutions.—From the Official Bulletin, California State Nurses' Association, District Five.

Questions

A small group of student nurses have caused a great deal of community gossip by running around with Tom, Dick and Harry. They think nothing of having social relations with the porters, orderlies, and ambulance drivers. They have been known to "pick up" men on the street, including married men. We believe that most schools today permit the student body to have social contact with the intern staff, off duty.

What can be done to stop the above practice? Who is responsible for the conduct of the students when off duty? Would it be ethical for the alumnae to take action, after other methods had failed? We don't believe that it would be ethical to go to the hospital administration. Do you think it would?

A Group of Graduate Nurses.

It is quite natural for the alumnae association to be concerned with such a problem. The difficulty is one of training school administration rather than of hospital administration, and might be discussed with the principal of the school by carefully chosen representatives of the alumnae association, with the intention of helping, and not merely of complaining or gossiping about the students. If there is no student government association, it is possible for such behavior to escape notice by the faculty.

Such difficulties arise from (1) acceptance of low grade students, and (2) failure to provide for adequate social activities for high spirited young people. The alumnae might assume quite definite responsibility for developing social activities which are desirable; for example, the "Big Sister" plan outlined in "The Spirit of the Alumnae" by Julia C. Stimson, in the *Journal*, May, 1925, has far-reaching possibilities. (Reprints may be had from the American Nurses' Association at ten cents per copy.)

An alumnae association might assume the responsibility for providing some of the equipment needed for social activities in the nurses' residence. Moving-picture machines, radio, china, silver and other equipment for parties, are suggested as means to ends.

The paper "The State in Relation to the British Nurse" raises the question of what is the status of the British registered nurse in this country. Probably no two state boards of nurse examiners have identical rulings. The New York board follows this procedure:

The applicant must present authentic evidence of the completion of the minimum education requirement in force at the time of her admission to a school of nursing.

In evaluating the professional course we accept for general medical and surgical training, a certificate of graduation from any school approved by the Council of England and Wales. If the applicant holds a midwifery certificate, this is accepted as evidence of the completion of a course in obstetric nursing.

We find the greatest difficulty in approving pediatric and nutritional experience, inasmuch as the courses in these subjects are organized in a rather different manner from ours. It is, therefore, usually necessary for the applicant to complete postgraduate work covering these services in schools of nursing approved by this department.

When the records submitted show a content of clinical experience equal to that required in this state, the nurse is permitted to participate in the licensing examination. Request is not made at present that the hours of formal instruction in the classroom be presented, although consideration is being given to this point. Upon the satisfactory completion of the licensing examination, a registration certificate of this state is granted.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

Why I Take the Journal

THE greatest inspirations to my professional life are the experiences and accomplishments of others in this great field. To read about the hardships and problems of these women who have reached great heights gives me new courage and hope. A few months ago I was wondering how I could prepare a show window in a downtown store. Where will I get a suggestion? This kept running through my mind. That very same morning the *Journal* came and, to my utmost surprise, there was a short article on window displays. I almost leaped for joy; just what I wanted came when I could use it.

In the public health field I find many nurses complaining of being lonely. Again I find the *Journal* a family letter; it keeps me in close touch with this great line of progress. The articles on technic in the different departments of nursing I find of great help. Like a boy with a new toy, I grasp my first opportunity to use it and compare it with my previous method. Work will not become tiresome and days will not be blue if we keep up with the new things and apply ourselves, constantly, to learning.

Last month, as I read the article regarding Miss Clayton, her life, her work and her death, a prayer went up from my heart to be a more efficient nurse, and a truer Christian. And so it is that with every issue of the *Journal* I find something interesting, something useful and practical.

Illinois. G. H.

Linda Richards—A Tribute

IT was with unconcealed emotion that I read a letter yesterday, which came to me in this far-off country, telling me of the death of my very dear old friend and benefactor, Linda Richards. Nor was I ashamed of the tears which came to my eyes as I read the letter. In my early days of nursing I had the great privilege of being closely associated with Miss Richards, and to know her was to love her.

Miss Richards was an inspiration to every one with whom she came in contact, and the world is richer for her presence. I remember so well the day that she received her certificate from the Massachusetts State Board of Registration. We were together in her room and she opened the certificate with a twinkle in her eye as she said, "Linda Richards, R.N. Now does that mean Real Nuisance?" I replied, saying that the State Board should have put B.C. on it also, which would mean Building Contractor, for Miss Richards always seemed to be building training schools for other people to occupy.

Now she is gone, but her work will live. Her entire life was characterized by the highest degree of service for others, and her very presence seemed a benediction. One great interest animated her life—her devotion to her calling. Miss Richards, the woman with the beautiful soul and rare sacrificial spirit, is gone from us to that greater school of learning, but her work will live forever.

REBA G. CAMERON, R.N.

Manila, P. I.

Problems of Reciprocity

I AM very anxious to hear from some of the nurses who are graduates of Southern schools of nursing, who have been unable to procure registration in New York State. Is it fair to nurses who have spent three years training and who are required to have a high school education, just because our hospitals are not registered by the Board of Regents of the State of New York? Is it fair to young women entering a nurses' training school in the South, when they are not told that they will not be able to get positions to which they might aspire should they have to make their homes in New York State? Circumstances are not always of our own making. Nurses from England and Canada come to our shore and are registered and get the best positions. But our real American-born nurse, if she is not from a New York registered hospital, has to take a back seat. It is not the education or the nursing ability that counts, it is the fact that if you are a New York R.N. that gets you the best position.

I am sorry to say that the state in which I am registered gives reciprocity to New York schools of nursing. We do not come to this

state to take the work from the New York nurses, any more than they come to our state where they are shown all the courtesy that can be extended to the outsider.

This letter is not written through malice, but if we are to be considered as only undergraduates, why should we spend three years in a training school? Being American-born, I feel we should be considered by our country.

A. R.

New York.

This writer confuses issues. The question of citizenship is not the paramount issue here. The problem is one of state standards, of the standards of individual schools and the preparation of individual nurses. Nurses desiring registration in New York, whether graduates of schools in New York state or in other states, must have graduated from *schools* approved by the New York Board of Regents—a ruling similar to that applied to other professional schools. Nurses from other states, who have been embarrassed by finding their schools not so accredited, have sometimes been instrumental in bringing about the inspection necessary before the school can be accredited.—*Editor.*

Journals *Wanted*

ELLEN L. BUELL, Chairman of the Library Committee, Henry Street Visiting Nurse Service, 99 Park Avenue, New York City, will be glad to purchase the following *Journals:* 1924, January, February, March; 1927, October.

M. A. Gibney, Director of the School of Nursing of the Norwalk General Hospital, Norwalk, Conn., would like the following *Journals:* 1900–1907; all of 1918; January, March, June, September, October, November and December, 1919; February, 1922; July, 1924.

Her Branch of Nursing

I'VE lost the card you sent, asking the branch of nursing. I'll send a statement: After graduating from a school in California, I did postgraduate work with the Victorian Order of Nurses in Vancouver, B. C. I came to Alaska under the Bureau of Education in 1916; married in 1918; widowed in 1924. I was reappointed as village nurse to Bethel, with a U. S. Dispensary as working center. It sounds great, and I certainly travel. In the mornings, village rounds; in the afternoons, dispensary hours; also evenings, if I chance to sit down to make my reports. Village visiting includes social service, village and general sanitation. By working all the year, I get the cans and trash cleared away by Easter. This takes the combined efforts of teachers, missionaries, critical sour-dough bachelors, and nurse. I do school nursing in two schools—territorial and native—where we keep records in personal hygiene as well as having weigh days at the dispensary for each school. Then there are follow-up work, emergency calls, and child welfare. By dint of much talk and making insignificants gifts, I have the mothers of the pre-school children coming each month for weighing and care. All who lose are given milk and cereal until the weight passes the danger line again.

These things I do, except for Sunday emergencies, the year round. Now you tell me what kind of a nurse I am, I don't know, but I do know that I find courage and help in my problems in both the *Journal* and the *Public Health Nurse*. *Hygiea* helps in my school talks, and the literature supplied by the Metropolitan Life Insurance Company is a real boon to this isolated, struggling, happy, though sometimes tired, nurse.

Alaska. S. A. H.

An Insurance Policy

RUTH LILLIAN LANE, Springfield, Mass., has a policy and money due her from the Prudential Insurance Company, according to J. J. Murrahy.

ALMA H. SCOTT,
Assistant Director, A. N. A.

Teaching under Difficulties

I HAVE just arranged to send my file of *Journals* for 1925 to another hospital superintendent. I have a training school of twenty-one nurses and I am the only graduate. I am instructor, supervisor, anesthetist, superintendent, etc. This has not given me as much time for study and constructive work as I would like and, too, my teaching is all in the vernacular, so everything must be translated for my nurses' benefit. I have made an index file for articles of special interest here by using my old recipe cabinet and just reversing the cards, writing my own titles.

India. R. H. S.

Miscellany

Jane A. Delano

DELANO, JANE AMINDA (March 12, 1862–April 15, 1919), teacher, nurse, descended from New England stock, was born at Townsend, N. Y., the second child of George and Mary Ann (Wright) Delano. After a brief period of teaching she entered the Bellevue Hospital School of Nursing, New York City, in 1884. Those associated with her during this period speak of her as a well poised, earnest student, so unobtrusive in her work that to few, if any, of her classmates did it occur that she possessed the force and character that would later bring her name and accomplishment before the eyes of the world. In 1887, the year after her graduation, she was superintendent of nurses at a hospital in Jacksonville, Fla., during an epidemic of yellow fever. The following year she gave pioneer service as a visiting nurse in a mining camp at Bisbee, Ariz. After a period of private practice she was appointed superintendent of nurses at the University of Pennsylvania Hospital School of Nursing, serving 1891–96. In 1898 she took a course at the New York School of Civics and Philanthropy. She was Director of the Girls' Department, House of Refuge, Randall's Island, New York, in 1900–02; and from May, 1902, to October, 1906, was Director of the School of Nursing at her alma mater.

During the Spanish-American War she had joined the New York Branch of the American Red Cross and become interested in securing nurses for enrolment in the Red Cross Nursing Service. After the reorganization of the American Red Cross in 1905, the national nursing associations secured an affiliation with that organization which placed the enrolment of nurses in the hands of state and local committees of Red Cross nurses supervised by a National Committee, of which, in 1909, Miss Delano, just appointed superintendent of the newly authorized Army Nurse Corps, was made chairman. While occupying this dual position she developed the plan for making the Red Cross Nursing Service the reserve of the Army Nurse Corps. From 1908 to 1911 she was president of the Board of Directors of the AMERICAN JOURNAL OF NURSING, and from 1909 to 1912 she was president of the American Nurses' Association.

She resigned from the Army Nurse Corps in 1911 to devote her entire time to Red Cross organization. A Bureau of Nursing Service was created in 1916 under which was placed the selection and assignment of nurses and organization of all military and other nursing units. A Department of Nursing was created in 1918 with Miss Delano as director. When the Armistice was signed the Red Cross Nursing Service had assigned 17,931 nurses to the Army; 1,058 to the Navy; 284 to the United States Public Health Service, while 604 were working under the Red Cross with the civilian population in the countries of the Allies. The Nursing Service also supplied 553 Red Cross aides for special work in France, and to the influenza epidemic in 1918, especially to war industries, over 15,000 graduate and practical nurses and volunteer aides.

The war over and the influenza epidemic allayed, Miss Delano sailed on January 2, 1919, for France, on her last tour of inspection. Developing a mastoid, from which she never recovered, she died at Savenay Hospital Center, April 15, 1919. It was characteristic of her devotion to the Red Cross that her last words were, "What about my work? I must get back to my work." It was also characteristic of her that, as a memorial to her mother and father, she should leave a legacy, together with the royalties from the *American Red Cross Textbook on Elementary Hygiene and Home Care of the Sick* (1913), which with Isabel McIsaac she found time to prepare during her busy Red Cross days, and to support one or more visiting nurses in communities where none existed. Many decorations were bestowed upon her by foreign countries; the Distinguished Service Medal of the United States and that of the American Red Cross were posthumously awarded.

From the fifth volume of the *Dictionary of American Biography*, Charles Scribner's Sons, New York.

Abstracts

Diagnosis of Pregnancy: S. Aschheim, M.D., translated by Alfred Plaut, M.D. The Early Diagnosis of Pregnancy by the Aschheim-Zondek Test. (*American Journal of Obstetrics and Gynecology*, March, 1930.)

When one implants 10 mg. of the anterior lobe of the hypophysis into the muscle of the thigh of an infantile mouse, the animal will go into estrus after four days. . . . The hypophyseal substance makes the infantile ovary mature, and this leads in its turn to the change in the vaginal epithelial cells. Thus it is the ovary we have to study for our pregnancy test, not the vagina or the uterus. . . .

The substance which, in the implantation experiment, makes the changes in the ovary, is present during pregnancy, . . . in the decidua, in the corpus luteum, in the placenta, in the amniotic fluid, in the young embryo, in the blood serum in large quantities, and most important, in the urine of the pregnant woman. This excretion of the hypophyseal hormone in the urine of the pregnant woman forms the basis of the Aschheim-Zondek pregnancy test.

Five infantile mice are necessary for the test. They are weighed and marked. Injections are made in the back, six in all, three on the first day and three on the second. One hundred hours later the mice are killed by illuminating gas and laparotomized. . . . The reading is done by inspection of the ovaries with the naked eye and with a hand lens. . . . The ovaries of untreated infantile mice are pale greyish pink and hardly the size of a pinhead. If all the ovaries have that appearance, the test is negative for pregnancy regardless of the condition of the uterus. The ovaries of mice after injection of urine from pregnant women are twice or three times larger and distinctly red, presenting submiliary yellowish protrusions which correspond to the corpora lutea, or cyanotic protrusions which are due to hemorrhage into a follicle or a corpus luteum. This is the positive reaction. It is often, but by no means always, accompanied by swelling and hyperemia of the uterus. If there is doubt, serial sections are examined with the microscope. . . .

The reaction becomes negative about the eighth day after delivery. It remains positive so long as living placental tissue is in biologic contact with the maternal blood. Therefore, in tubal gestation, we can expect a positive result only when the embryo is alive, or not later than eight to ten days after its death. But in the cases with living embryo the diagnosis is more important. After the death of the embryo the worst danger usually is over. The results in thirty cases of tubal gestation were in conformity with the clinical and operative findings. . . .

Gastric Syphilis: P. A. O'Leary, M.D. (The *Staff Meetings of the Mayo Clinic*, April 30, 1930.)

Summary. Of the eighty-nine patients with gastric syphilis who were selected from a group of approximately 25,000 patients who had syphilis, clinical cure was effected in 37 per cent, and the condition of 27 per cent was materially improved; the remainder of the group derived no benefit from treatment. The occasional dramatic results which have led many to believe that results in the treatment of syphilis are always startling are obtained from patients with the gummatous type of lesion. Those patients who derived little, if any, benefit from anti-syphilitic treatment were those with the type of involvement that is marked by interstitial fibrosis. Unfortunately, in this group, neither continued antisyphilitic treatment nor plastic gastric surgery offers any material help. The presence of clinical signs of syphilis is not a significant aid in the diagnosis of gastric syphilis. Neither does a negative Wassermann reaction exclude the possibility of the presence of syphilis. The therapeutic test, although not the most exact, is the most practical means of diagnosing gastric syphilis. In demanding that the *Spirochete pallidum* be recognized before the diagnosis is made, it is essential to specify the form of gastric syphilis that is suspected of being present. This study forcibly emphasizes the fact that is characteristic of all forms of syphilis; namely, that early diagnosis and early institution of treatment are rewarded by a higher incidence of cure than is obtained otherwise.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

Important actions were taken at the House of Delegates of the American Nurses' Association meeting in convention in Milwaukee. Of greatest interest, perhaps, were those affecting the Relief Fund. The advisability of discontinuing relief-giving on a national basis has been discussed, it will be remembered, for several years, those who have studied the situation having recommended a decentralization of the national fund for two reasons: (1) because the demands on the Relief Fund were steadily exceeding the income; and (2) because it is felt that relief-giving on a national basis is socially unsound.

The following actions on the part of the House of Delegates are, therefore, of interest and significance:

First, the House of Delegates adopted the resolution of the Relief Fund Committee, which resolution had been recommended by the Board of Directors of the A. N. A., and which was as follows:

"That after June, 1932, national relief be discontinued and that no further contributions to the Relief Fund be received; that nurses receiving relief be so advised and that the states be given the responsibility of dealing with their own relief problems; that the recommendations as to the future use of the Relief Fund principal be reserved for a later meeting of the Committee, and that the entire subject of the Relief Fund be discussed and acted upon at the Milwaukee Convention."

The House of Delegates then adopted the recommendation made by the Relief Fund Committee in the event that the delegates should vote to adopt the above resolution. These actions were taken only after considerable discussion had taken place on the part of various delegates, representing diverse opinions with regard to the Relief Fund. This second recommendation to be adopted was as follows:

"Moved by Miss Nelson, seconded by Miss Francis and carried that if it is voted to discontinue the Fund, the Relief Fund Committee recommends that the Committee be empowered to expend sufficient money from the Fund itself to study our situation in order to formulate some plan for meeting our already assumed obligations; to assist in making some constructive plan for the states desiring to continue relief projects, and to get assistance and advice in helping the Committee to prepare their final recommendations for the disbursement of the Fund itself."

Actions Concerning Dues

That most perplexing problem of dues was thoroughly discussed and actions were taken by the House of Delegates which promise to simplify the system whereby the dues of the individual member or of alumnae members find their way to the National Office. These are the actions taken in Milwaukee.

Dues

These changes were voted by the House of Delegates at the Biennial Convention, and were deemed necessary in order to provide for the collection and payment of dues during the same calendar year for which the dues entitle the nurse to American Nurses' Association membership.

Article VIII, as revised, now reads:

Section 1. The annual dues from each state association shall be fifty cents per capita.

Section 2. *Dues shall be paid in advance, not later than March 15, for the current calendar year, on the basis of membership, January 31.*

Section 3. *State associations whose dues*

have not been paid by April 15 shall be notified by the treasurer, and those not paying by May 15 shall forfeit membership.

Section 4. State associations having forfeited their membership may be reinstated upon the payment of dues for the fiscal year

Section 5. *Dues received by state associations after March 15 shall be paid monthly during each year.*

Article XV, Section 4, as revised, now reads:

To send to National Headquarters a classified typewritten list of all members with dues as provided in Article VIII.

This revision calls for some uniform plan for collecting dues from the alumnae associations and individual members of a district association to the district association treasurer (where the state is districted); from the district association to the state association; and from the state association to the American Nurses' Association if membership cards for state nurses' associations and transfer from one state association to another state association are to be effective.

The following plan for the collection of dues within the several state associations is, therefore, respectfully submitted:

DURING JANUARY of each year—
1. Collect alumnae association dues;
2. Collect individual dues;

BY FEBRUARY 15 of each year—
Send alumnae dues to district treasurer;

BY MARCH 1 of each year—
Send district dues for both alumnae and individual members to the state treasurer;

BY MARCH 15 of each year—
Send state dues to headquarters of the American Nurses' Association.

Please note:

I. *Dues collected during the year 1930.* Dues collected during the year 1930 as dues for American Nurses' Association membership for *1930*, whether for delinquent or for new members, are to be forwarded to National Headquarters not later than January 1, 1931.

II. *Dues collected during the year 1930 and up to March 15, 1931.* Dues collected during the year 1930, and up to March 15, 1931, as dues for American Nurses' Association membership for *1931*, are to be forwarded to National Headquarters not later than March 15, 1931, as provided in the revised Article VIII, Section 2, of the By-Laws of the American Nurses' Association, above noted.

III. *Dues collected after March 15, 1931.* Dues received by state associations during the year 1931, after March 15, 1931, as dues for American Nurses' Association membership for 1931, are to be paid monthly to the American Nurses' Association during 1931.

RESOLUTIONS

The past of nursing and the present of nursing were linked closely at the convention when the A. N. A. Resolutions Committee paid formal tribute to three great nurses who had died during the biennial period.

Among these resolutions was one carrying appreciation of the loss suffered by the American Nurses' Association in the death of its President, S. Lillian Clayton. It was resolved that the convention in session go on record as attempting to express its appreciation of her leadership, her sincerity, her sympathetic understanding, kindness and justice, and of her services for nurses and nursing and for the good of humanity.

Another resolution concerned Linda Ann Judson Richards, known as America's first trained nurse, who in 1873 was graduated from the New England Hospital for Women and Children, and who passed on at that hospital April 16, 1930. It was the desire of the Committee that the members of the A. N. A. acknowledge their indebtedness to the high qualities of leadership expressed in her professional life through the establishment of modern nursing in hospitals in this country, especially those for the mentally ill, and in hospitals in Japan as well.

It was further resolved that the members express their appreciation of the contribution of Anna C. Maxwell, to the Red Cross, to nursing education, and to the betterment of nursing standards, not only through her personal leadership but through her share in the production of a much needed textbook for nurses.

Other resolutions extended cordial thanks to the National Convention Committee; to the nurses of Wisconsin, under the leadership of Adda Eldredge, Cornelia Van Kooy, and Anna K. Rice; to the many committees which provided for the convention members' inspiration, profit, and pleasure during the convention; to the Program Committee, the monitors, and all those who contributed to the success of the convention; to the student chorus and its leaders; to the Boy Scouts and Girl Scouts; to the management of the Auditorium for the use of its spacious building and for the service rendered; to the city officials

and citizens for their courtesy and kindness; to the press for its generous interest and coöperation, and to the exhibitors for their courtesy and for the educational value of their exhibits.

Finally, it was resolved, in recognition of the heavy and unexpected responsibility which fell upon the shoulders of the First Vice President, Elnora E. Thomson, that the members voice their appreciation and gratitude for the courage and graciousness with which she "carried on the affairs of the Association."

Addition to Staff

On October 1, Ella Best will become Field Secretary of the American Nurses' Association, a position for which she possesses most excellent qualifications. Miss Best is a graduate of St. Luke's Hospital School of Nursing, Chicago.

After a brief period of private duty, she was for three years Instructor in Nursing in her Alma Mater. Following postgraduate study at Teachers College, New York, she became Instructor in sciences at Miami Valley Hospital, Dayton, Ohio, following this with two years of teaching at Michael Reese, Chicago, and that in turn with another year in her own school.

Since 1926, Miss Best has been assistant to the Dean of the school in Cook County Hospital, Chicago. A thorough student, Miss Best has had two summer courses at the University of Chicago and has been a part-time student in the University of Chicago Medical School.

Miss Best does not limit her interest to classrooms, nor yet to wards. All nurses and all of nursing are of interest to her. She has been active in her own alumnae association; she has been President of the First District Association, Illinois (Chicago), for several years, and has demonstrated rare qualities of leadership during a period of reorganization.

Since 1927, Miss Best has been Secretary of the Illinois State Nurses' Association when it, too, has been making a careful self-survey, with a view to important development. Still a young woman, Miss Best's consistent effort to develop her own powers, her generous devotion of time to professional developments in her city and state, point to a brilliant and serviceable future for her in the national field.

The Board of the American Nurses' Association is happy in its appointment, as they believe the membership will be in Miss Best's service.

Ella Best, R.N.

Nurses' Relief Fund

Report for Month Ending June 30, 1930

Receipts

Interest received on investments	$915.26
Interest received on bank balances	14.27

Contributions

Arkansas: District 6, B, $34; Leo N. Levi Alumnae Assn., $10	44.00
California: State Nurses' Assn.	244.50
Iowa: District 2, $69; District 3, $109	178.00
Kansas: State Nurses' Assn.	4.00
Kentucky: Norton Infirmary Alumnae Assn.	25.00
Michigan: State Nurses' Assn.	1,000.00
Mississippi: Individual contributions	5.00
New Hampshire: Alumnae associations—Margaret Pillsbury, $5; State Hospital, Concord, $10; Hillsborough County Hospital, $10; Beacon Hill Hospital, $5; Sacred Heart Hospital (Manchester), $25	55.00
New Jersey: District 1, alumnae associations—Mountainside, $92; Orange Memorial, $1; St. Barnabas, $25; individual members, $20; District 2, Bayonne, $3; Paterson General, $100, individual $1; District 4, St. Peter's, $25; individual, $1; District 5, Cooper, $2; individual, $2	272.00
Texas: District 1, $70; District 6, $1; District 14, $6; District 15, $2	79.00
Washington: Bellingham, $13; Tacoma, $15; Wanatchee, $7.50; Longview, $8.50; Walla Walla, $20; Everett, $15	79.00
	$1,985.50
Total receipts	$2,915.03

Disbursements	
Paid to 186 beneficiaries	$2,702.00
Collection charges	.15
Total Disbursements	$2,702.15
Excess of receipts over disbursements for month ending June 30, 1930	$212.88

All contributions to the Nurses' Relief Fund should be made payable to the *Nurses' Relief Fund* and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman, or the Director of the American Nurses' Association, Headquarters, 370 Seventh Avenue, New York City.

National Association of Colored Graduate Nurses

The NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES will hold its next annual meeting in Memphis, Tenn., August 12 to 15 inclusive. A large attendance is expected.

Army Nurse Corps

During the month of June, 1930, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: To Fort Sheridan, Ill., 2nd Lieut. Ada Davis; to Fort Sill, Okla., 2nd Lieut. Ruth A. Yates; to Fort Totten, N. Y., 2nd Lieut. Utie Kleibscheidel; to West Point, N. Y., 2nd Lieut. Florence Robinson; to Philippine Islands, 2nd Lieut. Frances Berger.

Seven have been admitted to the Corps as Second Lieutenants. Orders for Jessica Hermione Orso have been revoked.

The following are under orders for separation from the Corps: Second Lieutenants Sara H. Hammond, Selma E. Akason, Christine G. Fryhling, Virginia G. Moreland, Leala B. Hibbert, Lelia S. Christenbury, Nelda L. Anderson, Marie A. Eckman, Gladys H. Thomas, Elsie E. Hendershot, Emma J. Olson.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

REPORT FOR JUNE, 1930

Appointments: Ten.

Transfers: To Canacao, P. I., Ida E. Brooks, Florence A. Linderman; to Chelsea, Mass., Grace L. Goodwin, Muriel H. Neate, Marjorie E. Wheeler; to Guam, Sophie R. Hassler, Gertrude Sachs; to League Island, Pa., Janet C. McAdie; to Mare Island, Calif., Mary J. Jones, Mary F. Bosco, Ruth E. Cleaver, Elizabeth G. Mullen, Frances Ueman; to New York, Gertrude M. Dean, Mary M. Heck, Viola M. Visel, Janette Willis; to Norfolk, Va., Marie C. Boyle, M. Winifred Marsh, Beulah Taylor, Salie G. Wright, Ethel J. McCormack; to Philadelphia, Pa., University of Pennsylvania, instruction in anesthesia, Irene M. Mannon; to Puget Sound, Wash., Helen Ballerstedt, L. Corinne Mims, Elizabeth O. Jones, Lilla H. Sawin; to U. S. S. Relief, Helen I. White; to St. Thomas, V. I., Loretta V. Conner; to Washington, D. C., Cornelia A. Armstrong, Lucy H. Russell.

J. BEATRICE BOWMAN, R.N.,
Supt., Nurse Corps, U. S. Navy.

Helen M. Bunty, nurse, U. S. Navy, received one of the pens used by the President of the United States, on June 20, 1930, in signing the Act of Congress giving Army and Navy nurses retirement for disability in line of duty. The pen was accompanied by the following letter from the Superintendent of the Navy Nurse Corps:

"While it is recognized and appreciated that all members of the Nurse Corps were vitally concerned and most enthusiastic in supporting the interest for this measure, yet it fell to your lot to be in a strategic position where friendliness from those in power could be stimulated. This you accomplished with tact and courtesy becoming your Corps and your womanhood. Because of this we are happy to present to you this symbol of your loyal enthusiasm and your fidelity to the cause."

U. S. Public Health Service

The following transfers, reinstatements, and new assignments have been made in the U. S. Public Health Service during the month of June, 1930:

Transfers: To Norfolk, Va., Maude Greenleaf, Thelma Chappell; to Boston, Mass., Annie Rose Bransfield; to Chicago, Ill., Claudia Polski; to Cleveland, O., Ellen Cartledge, Ethelyn Everman; to Savannah, Ga.,

Evelyn White; to Fort Stanton, N. M., Frances Curry; to Evansville, Ind., Joseph Cassity; to Louisville, Ky., Nora W. Turville, Chief Nurse; to Hudson St., New York City, Jennie Martell, Acting Chief Nurse.

Reinstatements: No reinstatements during the month of June.

New Assignments: Mary Louise Huber, Altha Gantz, Wilhelmina Shuck, Anna Shoemaker, Pearl Kubeck, Edna Kranz, Flossie Jones, Katherine McHugh, Beatrice Wolford, Anne Douglas Howe, Mabel Neikirk, Ethel McGill, Ethel Hannon, Naomi Moore, Mary K. Wood, Olive Neal.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

United States Veterans' Bureau

REPORT OF NURSING SERVICE, JUNE, 1930

The permanent hospital construction program of the Veterans' Bureau is being completed at emergency speed. The sites of the new hospitals are being located as near as practicable to the center of the disabled military population, taking into consideration climate, accessibility, water and other necessary matters. Generally speaking, it may be assumed that the largest hospital load always comes in the vicinity of the large centers. This is particularly so with the neuropsychiatric load.

Some idea may be had of the problems which confront the Bureau when one realizes that it has been estimated that the hospitalization of 7,700 non-service connected cases is equivalent to operating fifteen 500-bed hospitals, and this problem is growing from year to year.

The new construction at the Veterans' Bureau 550-bed hospital at North Chicago, Ill. (the Great Lakes), it is expected will be ready for the reception of patients about August 15. This will provide 300 additional beds, nurses' home and other facilities. This hospital is for the care and treatment of neuropsychiatric cases only. It will be seen that there is a field and future prospects for nurses in neuropsychiatric nursing.

During the past month the Superintendent of Nurses, Mary A. Hickey, visited the following Bureau facilities, for the purpose of supervising the nursing activities and making constructive plans for the betterment of the work: Des Moines, Iowa; St. Louis, Mo.; Milwaukee, Wis.; Hines, Ill.; North Chicago, Ill.; St. Cloud, Minn.; Fort Snelling, Minn.; Knoxville, Iowa; Kansas City, Mo.; Jefferson Barracks, Mo.; Waukesha, Wis.

During the month of June the following-named nurses have been reinstated: Mary Scarborough, Harriet K. Luther, Florence Kerr Causby, Zilla M. Clark, Lillian Hill.

Assignments: Nineteen.

The following have been separated from the service: Serine Aarestad, Elinor A. Brinson, Lillian Bowie, Anna L. Caldwell, Edna C. Cannon, Josephine Chelf, Emilia B. Eggena, Hannah J. Flahive, Mame P. Freeman, Anna H. Gjevre, Emma J. Hall, Lucile Hardy, Kathryn Hussey, Inez Hurte, Lula M. Johnson, Velma Helmberg, Florence Kyle, Rose A. Leddy, Mary C. Lindsey, Mary V. Mahany, Laura E. McKinnon, Alice M. Morrissey, Vivienne R. Patrick, Clara L. Parker, Josephine Phelps, Flora E. Ritchie, Margaret M. Roach, Valborg C. Simonsen, Katherine Tilton, Louise A. Wade, Mary Maroney.

Transfers: To Minneapolis, Minn., Alice Ryberg.

MARY A. HICKEY,
Supt. Nurses, U. S. V. B.

U. S. Indian Service

During the month of June, the following changes took place in the nursing personnel of the Indian Service:

Appointments: Two.

Separations: Four.

Transfers: To Cherokee School, North Carolina, Edith L. Alexander.

ELINOR D. GREGG,
Supervisor of Nurses.

Hospital Standardization Conference

The thirteenth annual meeting of the HOSPITAL STANDARDIZATION CONFERENCE of the American College of Surgeons will be held at the Bellevue-Stratford Hotel, Philadelphia, the week of October 13, the same week as the Clinical Congress.

The program will deal with ways and means of improving all phases of hospital administration, more particularly as related to the economic and efficient care of the patient. It will consist of addresses, papers, round table conferences and general discussions. These will embrace such practical topics as the following: "What the Hospital Standardization Movement Means to the Present-Day Practice of Medicine"; "What Is the Ideal Hospital?"; "Problems of the Rural Surgeon and

Their Solution"; "Coöperation in the Hospital"; "Is the Private Patient Getting a Square Deal?"; "The Hospital's Teaching Responsibility"; "The Rôle of the Student Nurse in the Clinical Record"; "Case Records and Staff Conferences." There will be two interesting round-table conferences, one dealing with "Functions, Relationships, and Responsibilities—Boards of Trustees, Medical Staffs, and Superintendents"; and another, "Medical and Hospital Economics."

Those charged with the responsibility of preparing the program have kept in mind the various interests concerning, namely, hospital trustees, hospital executives, members of medical staffs, nurses, social workers, dietitians, technicians, record librarians and others concerned with the welfare of the patient. In this way the program will be of the broadest interest and greatest practical benefit to all present. Recognizing that the success of any program depends on the variety and thoroughness of the discussions, ample time will be given to the presentation of each topic. In every way the college is desirous of making this conference a clearing house for hospital problems as well as the presentation of end results from well-tried methods or procedures as affecting the many administrative problems involved in the care of the patient. A most cordial invitation is extended to all to attend.

The American Dietetic Association

THE AMERICAN DIETETIC ASSOCIATION will hold its thirteenth annual convention in Toronto, Ontario, Canada, September 8, 9, and 10.

State Boards of Examiners

Michigan: The MICHIGAN BOARD OF REGISTRATION OF NURSES will hold an examination for graduate nurses in Marquette, September 9 and 10, 1930. An examination for trained attendants will be held on the same dates. The Michigan Board of Registration of Nurses will hold an examination for graduate nurses in Detroit, October 9 and 10, 1930, and one in Lansing, October 23 and 24, 1930. An examination for trained attendants will be held on the same dates.

Mississippi: The President of the MISSISSIPPI STATE BOARD OF EXAMINERS OF NURSES is now Mary H. Trigg, King's Daughters' Hospital, Greenwood.

Georgia: An examination for graduate nurses will be held October 8–9 in Atlanta, Augusta, Macon, and Savannah, provided sufficient number of applications are received. Apply to Jane Van De Vrede, Secretary, 131 Forrest Ave., N.E., Atlanta.

State Associations

Connecticut: The fall meeting of the GRADUATE NURSES' ASSOCIATION OF CONNECTICUT will be held in New Britain, October 3, 1930.

Florida: The FLORIDA STATE NURSES' ASSOCIATION will hold its annual meeting, November 4–5–6, at West Palm Beach. Katherine Gutwald, Good Samaritan Hospital, West Palm Beach, is Chairman of the Program and Arrangements Committee.

Indiana: The INDIANA STATE NURSES' ASSOCIATION will hold its annual meeting at the West Baden Springs Hotel, West Baden Springs, September 26, 27. For details regarding arrangements, see the *Journal* for July, page 946.

Kentucky: The officers of the KENTUCKY STATE NURSES' ASSOCIATION are: President, Anna H. Ryan; vice presidents, Emma Lou Conway and Mrs. A. E. Johnson; recording secretary, Joy Frazer; corresponding secretary, Mrs. W. T. C. Poulson; treasurer, Harriet Cleek. All are of Louisville except Miss Cleek, who is in Lexington. The chairmen of committees are: Ways and Means, Mrs. Myrtle Applegate; Press and Publication, Edna Houston; Credential, Louree Pottinger; Arrangements, Alice Gaggs; Program, Sophia Steinhauer; Nomination, Lake Johnson.

Massachusetts: The following are the officers who will serve for the coming year in the MASSACHUSETTS LEAGUE OF NURSING EDUCATION: President, Blanche A. Blackman; Springfield; vice president, Susie A. Watson, Boston; secretary, Gertrude E. Maloney, Boston; treasurer, Mary E. Gilmore, Boston; directors, Bertha W. Allen, Frances L. Ladd, Helene G. Lee.

A CORRECTION—Through an error (not ours) the list of officers of the Massachusetts State Nurses' Association published in the July *Journal* is incorrect. The secretary is Mary Alice McMahon, Boston State Hospital, Boston.

Minnesota: Minnesota nurses regret that two of their long-serving faithful members are to leave the state, and wish to record their appreciation of the work and influence of

Bertha Matlick and Marion Vannier. Miss Matlick has been Superintendent of Hillcrest Hospital for twenty-one years, and active in district and state work, serving on many committees and as President of the Minnesota League for two terms, 1921–22. Miss Vannier has been with the University School, first as instructor, then assistant to Louise Powell, and since Miss Powell's retirement, Director of the school. She has always been interested in organization affairs and in the institutes which led to the establishment of the summer courses in teaching and administration, and has coöperated in all movements for the interests and development of nursing education and activities. She will live in California. Both Miss Matlick and Miss Vannier were guests of honor of the League at the meeting in May, and of Third District at a tea in June. There were 178 names on the Minnesota Register at the Biennial, and 134 attended the Minnesota dinner at the Republican Hotel on Wednesday night. The subject of the after-dinner program was, "What's What and Who's Who," and a happy spirit prevailed as each one present told who she is, what she does, and what her hobbies are. Mary E. Gladwin and Mary Marvin were introduced as guests. Miss Gladwin and Miss Cornelisen gave short talks.

Oregon: The twenty-third annual meeting of the OREGON STATE GRADUATE NURSES' ASSOCIATION, in conjunction with the Oregon League of Nursing Education, was held at Portland, June 27 and 28. The business meeting of the League of Nursing Education was held at the Central Library, the business meeting of the State Association, and the joint social meetings were held in the new St. Vincent School of Nursing. Very interesting reports were given from the different districts and a good attendance was had. During the past year six new districts were organized and two old districts reorganized. The 1930 membership shows a gain of over 36 per cent more than for 1929.

Jane D. Gavin, President of the Oregon State Graduate Nurses' Association, gave a report of the Milwaukee Convention in general; Margaret A. Tynan, Chairman of the State Central Headquarters and Registries Committee, reported on "Registries"; Rufina McDonald gave an interesting report on the meetings of the Private Duty Section; Mrs. Glendora M. Blakeley gave a report of the convention from the Public Health angle; and Grace Phelps reported for the League of Nursing Education meetings. These reports were very interesting and lengthy discussion followed each. Great interest in the Biennial was shown in Oregon, as sixteen nurses attended, while the membership entitled the state to only ten delegates.

Following the business meeting, Mrs. Saidie Orr Dunbar, Executive-Secretary of the Oregon Tuberculosis Association, gave a very comprehensive report of the White House Child Health Conference. Jennie Hunter, Physiotherapist, Shriners' Hospital for Crippled Children, gave a lecture and demonstration with patients on "Physiotherapy" with particular attention to the care of post-acute poliomyelitis. Dr. Ralph C. Matson, President of the American Sanatorium Association, gave an address on "Newer Surgery and Anaesthesia in Tuberculosis," illustrated by slides. Daisy Dean Urch, President of the California State Nurses' Association, brought the meeting to a close with an address on "Higher Education for Nurses." Following the conclusion of the social sessions, the report of the tellers was read, which showed the following officers and Board of Directors members to be elected: President, Jane D. Gavin; vice presidents, Helen McCusker, Freda Folkman; secretary, Mrs. Louise H. Cliff; treasurer, Violet Kirschner; directors for three years, Cecil Schreyer, Beth Freeman, Hope Brady.

South Dakota: The SOUTH DAKOTA STATE ASSOCIATION held its annual meeting in Rapid City, July 29–30, too late for a report in this *Journal*. A report will appear in the September number.

Wisconsin: The newly elected officers of the WISCONSIN LEAGUE OF NURSING EDUCATION are: President, Ethel Odegard, Milwaukee; secretary, Ida C. Baar, Milwaukee.

District and Alumnae News

Connecticut: Hartford.—Sister Catherine Teresa Rodgers and Sister Alice Mary Leary, graduates of St. Francis Hospital School of Nursing, have returned to take charge of the dietetic department and serve as instructors, after completing a course at the Pratt Institute, Brooklyn.

Illinois: Chicago.—The third regular meeting of the FIRST DISTRICT was held at the Chicago Woman's Club, June 17, Ella Best presiding. Reports of the Biennial Convention were presented by Harriet Fulmer, Mrs. Gertrude Simpson, Katharine Holfeltz, and Frances Heinrich. As part of her report Miss Heinrich read the paper which she had given at the convention on "Hospital Relationships

from the Private Duty Angle." A report of the Illinois Dinner was given by Hettie Gooch. Announcements made from the chair were as follows: The three scholarships of $250 each, given by the District, were awarded as follows: The S. Lillian Clayton Scholarship for a private duty nurse, to Helen Sharp, graduate of the Evanston School of Nursing; for a public health nurse, to Sarah Ann Shannon, Passavant School of Nursing; for an institutional nurse, to Bernice Seegmiller, Presbyterian School of Nursing. In the campaign for increased membership in the State Association, which closed May 26, the $50 prize for securing the largest number of new members, as a district, was given to Second District. Geneva Martin of Sixth District won the $50 prize for securing the largest number, as an individual. **Rockford.**—ROCKFORD HOSPITAL held graduating exercises for a class of seven at the Court Street M. E. Church on May 28. The address was given by Dr. John Gordon.

Iowa: Des Moines.—Mary Ella Chayer, formerly Supervisor of School Nursing and a Director of the Seventh District, has gone to New York to become an instructor in school nursing in the Department of Nursing of Teachers College.

Louisiana: Alexandria.—The ninth annual meeting of the ALEXANDRIA DISTRICT was held June 10, at Victory Hall, with forty in attendance. Officers elected are: President, Mrs. Bertha McManus Ball; vice presidents, Mrs. Vera Roan, Mrs. George Guillory; secretary, Leila Dunn; treasurer, Mrs. Ella Herrin; councillors, C. Gravel, Mrs. Annie Sutfin, Belle Harper. Chairmen of committees are: Legislative, Carrie Hale; Program, Mrs. A. O. Campbell; Printing, Mrs. A. Wallace; Credentials, Mrs. G. Guillory; Nominations, Mrs. E. Stalsby. A short oration was given to the memory of S. Lillian Clayton, President of the American Nurses' Association, who died May 2. A short session of the private duty section was held, Mrs. A. O. Campbell presiding. Section officers elected are: Chairman, Mrs. A. O. Campbell; vice chairman, Mrs. Blanche Nettles; secretary, Myra Kelly. The retiring District President, Cornelia Gravel, outlined the Association's progress and its present status. A fine address was delivered by Dr. R. O. Simmons on the "Relation of the Nurse to the Doctor." Papers were read by Miss M. Dansereau, Superintendent of the Central Louisiana State Hospital, Pineville, on "Psychiatric Nursing," and by Lillian Goodwyn, recent graduate of the Baptist Hospital, on "Progress of Nursing." Myra Kelly explained "Courtesy" in a well-written paper. **New Orleans.**—The NEW ORLEANS DISTRICT held a regular quarterly meeting on June 26, at the Club House, J. I. McCaughn presiding. A speaker sent by the Association of Commerce presented "The Duties of a Citizen." Several applications for membership were accepted, but others were held up because their alumnae associations had failed to reply to letters from the Credentials Committee; no new member will be accepted without such credentials. The position of Executive Secretary was created, to be filled by the Board of Directors. It was decided to advertise the Directory and to have socials twice a month. It was also decided to have rooms for nurses in the Club House, instead of apartments. An interesting report of the Biennial Convention was given by the delegate, J. Bayhi. At a meeting of the Directors, held June 30, Mrs. Annie L. Smith was appointed Executive Secretary. It was decided to allow her one month to study the situation and report her findings, before defining her duties.

Massachusetts: Waverley.—THE MCLEAN HOSPITAL NURSES' ALUMNAE ASSOCIATION held its annual meeting and reunion at the hospital. Over 200 nurses visited the hospital during the day. Dr. Kenneth Tillotson welcomed them and gave an instructive talk on "Mental Hygiene," with gleanings from the International Congress held at Washington in June. An educational loan fund was established at this meeting, and the sick nurses' relief fund is rapidly growing.

Missouri: Kirksville.—The Alumnae Association of LAUGHLIN HOSPITAL held its annual meeting on July 1, following a picnic given to the graduating class. Officers elected are: President, Edna Hirchler; vice president, Mrs. Joe Bigsby; secretary and treasurer, Mrs. Jack Frost. **St. Louis.**—Commencements of the various schools are over; the schools graduated classes as follows: Central, 13; City, 27; Jewish, 29; Josephine, 6; Lutheran, 18; Missouri Baptist, 48; St. John's, 31; St. Luke's, 41; Washington University, 41. The new Deaconess Hospital was dedicated May 28. Each afternoon of the following week it kept open house.

New York: Brooklyn.—A PUBLIC HEALTH EXPOSITION will be held in October next, under the auspices of the Medical Society of the County of Kings and the Second District Dental Society, in the 23rd Regiment Armory. The BROOKLYN STATE HOSPITAL held graduating exercises for a class of five,

on July 12, at the hospital. The address was given by Hon. Hugo Hirsh. **Clifton Springs.**—The June meeting of the LEAGUE OF NURSING EDUCATION was held at the Clifton Springs Sanitarium on June 17, and was a report of the convention in Milwaukee, followed by a picnic. Arrangements for a course in the University of Rochester for supervisors and head nurses in "Methods of Teaching" has been completed. The course will cover a period of fifteen weeks and will begin in September. Laura McGregor of the Department of Education of the city is to give the course. **New York.**—The Katherine A. Sanborn Scholarship was founded this year by the ALUMNAE ASSOCIATION OF THE ST. VINCENT'S HOSPITAL SCHOOL OF NURSING as a tribute to Miss Sanborn, the Director of the school for thirty-eight years. The scholarship provides an annual purse of $600 and is to be awarded yearly to a member of the Alumnae Association who is desirous of extending her nursing education. **Troy.**—The SAMARITAN HOSPITAL held commencement exercises for a class of nineteen at Hendrik Hudson Hotel, June 20. The address was given by Nina D. Gage.

North Carolina: District 1, Asheville.—The regular monthly meeting was held June 11, the vice president, Jane Brown, presiding. The June *Bulletin* from National Headquarters was read, and the article on "Hourly Nursing" was discussed with interest. Leckie Ballard, of Greensboro, Acting Secretary of the State Association, was present and made a short address. A committee, with Mary P. Laxton, Chairman, was appointed to serve with the President in making a study of the state constitution and by-laws. The RUTHERFORD HOSPITAL ALUMNAE ASSOCIATION held the annual meeting at the Nurses' Home on June 5. The following officers were elected: President, Myrtle Hemphill; vice president, Eugenia Twitty; secretary-treasurer, Exodee Blackwell. The BILTMORE HOSPITAL ALUMNAE ASSOCIATION held the regular meeting on June 4, at the Nurses' Club. Miss Noyes' excellent paper on "Linda Richards" was read by Mrs. Charles Jenkins. A study of the alumnae constitution and by-laws was planned, and each member provided with a copy. As several alumnae members have recently accepted positions out of the State, it was found necessary to appoint several new committees. The meetings in the future will be held at 223 Chestnut Street, as centrally located and convenient. Each member present assumed the responsibility of bringing another member to the meetings. **District 3, Winston-Salem.**—The regular meeting on June 26 was held with good attendance. A most interesting report of the Biennial Convention was given by Mary Oliver. **District 5, Durham.**—After the usual business session, R. B. Reese spoke, at the regular District meeting in June, on the "Value of Life Insurance for Nurses." A memorial service was held in honor of S. Lillian Clayton, late President of the American Nurses' Association, and Linda Richards, America's first graduate nurse. **District 9, Wilmington.**—The regular meeting in June was in charge of the vice president, Mrs. A. J. Peiffer. Tributes to the life and memory of S. Lillian Clayton were read by Columbia Munds. The June *Bulletin* from National Headquarters was read with interest. Janet Geister's letter, following the Institute for Executive Secretaries, held in New York in March, was re-read and discussed. A resolution was adopted that the District appropriate funds for the maintenance of North Carolina State Headquarters for one month as its contribution to the work for the coming year.

Ohio: Canton.—DISTRICT 1 held its regular meeting at Meyers Lake Park, July 15, with the program in charge of the Educational Section. **Findlay.**—DISTRICT 13 held its regular meeting at Findlay Country Club, July 28. Dr. Hartmen of Findlay gave a talk and Mary L. Margerum gave a report of the Biennial Convention.

Pennsylvania: Ashland.—The meeting of DISTRICT 2 was held at the Nurses' Home, Ashland State Hospital, with a large attendance. Following the business session, K. Frances Cleave, Nursing Consultant of the State, gave a very interesting talk on "The Functions of the Welfare Department." A demonstration of "Isolation Technic" was given by a senior student. Inspection was made of the new nurses' home and a tour of the hospital followed. **Braddock.**—BRADDOCK GENERAL HOSPITAL ALUMNAE ASSOCIATION held its regular meeting, June 9, in the Nurses' Home. Plans were made for a theatre party to be held in October, the proceeds to go to the Hospital Building Fund.

Philadelphia.—Loretta M. Johnson, Philadelphia General Hospital School of Nursing, 1922, has been appointed Superintendent of Nurses at the Philadelphia General Hospital. Following her graduation Miss Johnson was assistant instructor, then instructor in Practical Procedures. She then became a supervisor. Miss Johnson has been also Superintendent of Nurses in a small hospital and

has spent some time at Teachers College.

White Haven.—The annual meeting of the WHITE HAVEN SANATORIUM TRAINING SCHOOL FOR NURSES ALUMNAE ASSOCIATION was held in the classroom of the Sanatorium, on June 14, nineteen members being present. The following were elected to office: President, Viola Comsick; vice president, Beatrice V. Foote; secretary-treasurer, Estelle Doherty.

West Virginia: Charleston.—The graduation at one time of the senior pupils of five schools of nursing was something new, and marked a decided advance. The exercises began on Sunday, May 11, and were conducted by St. Barnabas' Guild, as a baccalaureate service and a memorial to Florence Nightingale. The Seniors marched in uniform to St. John's Parish House, followed by the students. The tribute to Miss Nightingale was given by the Superintendent of School Nurses, and the sermon was preached by Rev. George Taylor. On Monday, May 12, all the hospitals kept open house. The Kanawha Valley Hospital gave a party for the 200 babies who had been born there within the past three years. On the evening of May 14, came the graduating exercises, held in the new high school, when the twenty-nine graduates preceded the five superintendents, and the alumnae, 174 in number, many of whom had come from other towns to do honor to the occasion. The address of the evening was given by Mrs. Elsie Butler Groves of Columbia University, New York. On the evening of May 15, the various alumnae associations entertained the classes at dinners, and on the next evening there was a dance. Great credit for the success of the first community commencement is due the superintendents of the five schools who showed a spirit of enterprise, vision and co-operation.

Wyoming: Sheridan.—The regular meeting of DISTRICT 3 was held at the Nurses' Home of Sheridan County Memorial Hospital, June 18, and the following officers elected: President, Pearl Summerford; vice president, Mrs. Agnes Donovan; secretary, Marion Kent; treasurer, Mildred Webber; directors, Alice Chappel, Mrs. Laura Gilbert, Mrs. Jack Webb. The student nurses at the SHERIDAN COUNTY MEMORIAL HOSPITAL are now enjoying the new tennis and basketball courts provided for them by the kindness of the medical staff, business houses, and private denominations. These courts are sincerely appreciated by the nurses.

Deaths

Stella Lillian Baum (graduate of St. Luke's Hospital, St. Louis, Mo.) at Brooklyn, N. Y., after a lingering illness. Burial was in St. Louis.

Mrs. Effie Warner Corey (class of 1897, Arnot Ogden Memorial Hospital School of Nursing, Elmira, N. Y.) on June 16, from injuries received in the collapse of a building. Mrs. Corey did private duty for a number of years, and was truly loved by all her patients. The last several years she had acted as Visiting Nurse with the Federation for Social Service in Elmira. A woman of a very kindly, sympathetic nature, her ministrations and patient attendance won her the friendship of many. A practical Christian, her life work carried out the principles of her religious beliefs. As one of the faithful, active members of the Alumnae Association, her spirit and coöperation will be greatly missed. She will be remembered as a real friend and a true nurse.

Agnes Ward Peltier (class of 1912, St. Vincent's Hospital, New York) recently, at her home in Hartford, Conn. Mrs. Peltier was one of the first nurses to go abroad in the spring of 1915, to give her services during the World War. Although she had been in poor health for some time, the news of her death came as a great shock to her friends.

Avis Fletcher Scott (class of 1914, Jewish Hospital, St. Louis, Mo.) on June 18, at Huntington Park, Los Angeles, Calif., after an illness of several months. Prior to her marriage, Mrs. Scott was supervisor of the x-ray department in her own hospital, superintendent of a hospital in Bethany, Mo., and of Green Gables Sanitarium, Lincoln, Nebr.

Sister Mary Edward (class of 1918, T. E. Schumpert Hospital, Shreveport, La.) on March 22, at St. Mary's Hospital, Long Beach, Calif., after a severe illness. For years Sister Mary Edward had labored untiringly among the sick; she had been a member of the community at St. Mary's Hospital for the past three years. Her joyful, loving spirit made her the life of any company in which she was. Although she must have suffered greatly in her last illness, she did not utter a word of complaint. Her associates say of her that she was never known to do an unkind thing. She will be greatly missed by her associates.

About Books

DERMATOLOGY AND SYPHILOLOGY FOR NURSES. By John H. Stokes, M.D. 311 pages. 69 illustrations. W. B. Saunders Company, Philadelphia. 1930. Price, $2.50.

IN the past, with few exceptions, when a medical man prepared a textbook for nurses he simply gathered together a few medical oddments, added an occasional sentence on don'ts for the nurse and christened the result "A Textbook for Nurses." Consequently, it is refreshing to read Dr. Stokes' *Dermatology and Syphilology for Nurses*, for here an entirely new policy has been inaugurated; from cover to cover it is written for the nurse. It is distinctly not a compilation of other books, not a résumé of former works, but a book written primarily for nurses by a leader in the field of dermatology and syphilology.

The book differs from other similar works in so many respects that it might be termed revolutionary, for the approach is from an entirely new angle. All undesirable terminology has been omitted, and simple, understandable language is the rule. There are no lengthy discussions on moot points of etiology, but established facts are tersely and forcibly stated in clear, concise language. There is no perplexing the reader with doubtful bacteriological findings, but important points are set forth so clearly that they must register.

A very valuable addition is a sort of summary, separately spaced and blocked, at the end of each chapter, bringing still more forcibly to the attention of the nurse important factors in the management of nursing care. True, many of these "thumbnail sketches," as Dr. Stokes so aptly calls them, are titled "Treatment for . . . ," but they deal solely with the manner in which the instructions of the physician are to be carried out and allow the nurse no leeway in the matter of prescribing or suggesting treatment. The author is especially insistent that the nurse realize her part in the play. She is not to devise treatment, but to carry out instructions, and it is his explicit teachings in this respect that makes the book so valuable.

Not alone is Dr. Stokes emphatic in his teachings of *what to do*, but he is equally emphatic in his admonitions of *what not to do*, as, for example, the chapter dealing with the preparation of a patient for x-ray therapy. The injunction to remember that you are dealing with the "Dangerous Unseen" should be emblazoned on the walls of every x-ray laboratory. On page 130, Fig. 27, there is a summary, for the nurse administering x-ray treatment, consisting of twenty rules, which is unequaled for brevity and yet is so clear and comprehensive that no nurse could possibly err in the application of this treatment. Of equal moment are the instructions to patient taking x-ray treatment.

Chapter XX, "Diagnosis and Diagnostic Tests in Syphilis: Darkfield, Blood, and Spinal Fluid," written in simple understandable English, clarifies the technic and the like of the

various serologic tests which are so confusing to most minds.

The book is not overcrowded with illustrations, but a number of clear plates add to its value.

It would be unfair to this really great little book to omit a word of praise of Part IV, which deals with the principles of social hygiene. This is really a heart-to-heart talk with nurses by a man thoroughly versed in every phase of this enormous problem of social medicine—a foremost medical man, a master in both the art and science of his profession. Beginning with "Social Hygiene and the Nurse," passing to the "Social and Economic Background of Syphilis and Gonorrhea," then to "The Organized Venereal Disease Control and Social Hygiene Movements," and terminating with a truly beautiful viewpoint on "Normal Ideals of Sex Life," it gives the reader not alone valuable instruction, but genuine pleasure. No one can fail to be impressed with the lofty ideals and the sincerity of the author.

The style of writing makes delightful reading. The beauty of the language may be appreciated from the following quotation taken from Chapter XIX, "The History, Cause and Prevalence of Syphilis":

> There is not an aspect of the whole field of medicine and surgery and all the specialties into which it does not thrust itself. Its history contains the essential element of the dramatic. According to the most widely accepted view, it sprang from ambush, so to speak—a direct importation by the sailors of Columbus, from the island of Haiti. It has swept the world in devastating epidemics, and defeated vast armies more effectively than pike, powder and shot. It has been immortalized in poetry, has held the stage at the center of medical discussion, and its treatment furnished the first and most memorable of the triumphs of chemical science over disease. And more intriguing than all that, for the average man, is its Machiavellian cunning. Insanity, death, hover in its wings and strike from the clear sky among our friends and intimates impartially with the great ones of the earth. Three children in a hundred, and from five to ten adults have the disease. In hospitals as high as twenty patients in a hundred have the disease. It has been believed to be incurable. Through the comparatively short cycle of centuries in which it has been at work it has, through its inherited form, modified the entire destiny of mankind, and left its stamp upon the race. No genealogic tree is so pure that syphilis has not twined itself among its branches. Small wonder, then, that it is easy to write about syphilis, easy to study it and easy to hold audiences with its story.

There is no other textbook for the nurse which so faithfully, so graphically, and so beautifully describes the tragedy of syphilis.

ANN DOYLE, R.N.

New York

HOSPITAL ECONOMICS FOR NURSES. By Phoebe Miller Kandel, R.N. 276 pages. Harper and Brothers, New York. 1930. Price, $5.

THE advent of this volume on the subject of hospital housekeeping will be hailed with delight by both educators and administrators, since it aids much in their mutual problems. The opening chapters serve as excellent orientation material to the mind of the young student. They give a very readable, broad concept of the ramification of interests involved in hospital construction, thereby developing an appreciative attitude on the part of the student through rational, rather than emotional, approach. From this point, it is but logical that the author next develops the need of close coöperation and complete understanding between the nursing personnel and administrative departments. Only in this manner is a sound economic basis of operation and maintenance secured. Further interest and intelligent evaluation of hospital

equipment is developed for the student, by a careful explanation of sources of raw materials and different types of construction with the reason given which prompted their variation —this, in itself, ought to go far to eliminate thoughtless criticism and misappropriation of materials by staff members; it ought to go far to make all more alert and resourceful in the use of that equipment, as well as appreciative of the many persons and the painstaking work involved in its production.

From the general background of the hospital, the book follows the natural order in the experience of the student by discussing the planning, construction, equipment, staff, and general care of the nurses' residence. With this information the reader is well prepared for the more detailed chapters which follow, on ward equipment; cleaning of wards and cleaning of equipment; replacement of supplies; care of linens; supply and disposal of foods and waste; discussion of the part played by the hospital pharmacy; and last, but of great importance, the removal of stains and control of insects and rodents. In these pages are included price lists which ought to aid greatly in destroying the tendency of many students to take for granted the unending source of supplies furnished for their use. The purchase price of linens, dishes, mattresses, etc., is far too often a matter of no consideration to the nurse because that fact has never been placed before her. Carefully made "process charts" call attention to the interrelation of construction and work necessary to maintain and clean equipment.

The final chapter and appendix on Personnel Management would be of more value to the head nurse, supervisor and nursing administrator than to the student, for its principles are rather beyond her scope. To those of higher responsibilities the author gives many helpful suggestions in her lists of duties and schedules for ward maids, orderlies, and porters. The approximate costs of certain drugs, enamelware, rubber goods, cotton, etc., ought to serve as splendid teaching material for the ingenious head nurse who wishes to aid her staff in developing a sense of economic use of ward supplies.

Valuable review questions are listed at the end of each chapter as well as collateral bibliography. Throughout the book one has the persistent feeling that the author has left no stone unturned by which she might make sure of her statements before their publication. Many experiments have been performed for collecting her data; careful, detailed research has ferreted out facts on which she has based her discussion. Whether for text or reference use we have reason to be truly grateful for this addition to our professional library.

DOROTHY ROGERS, R.N.
Missouri

ETHICS. TALKS TO NURSES. By Mary E. Gladwin, R.N. 281 pages. W. B. Saunders Company, Philadelphia. 1930. Price, $2.

UPON a background of wide and appreciative reading and long experience in nursing of many kinds in many places, Miss Gladwin projects, in limpid prose, a few of the eternal verities of ethics. "Few of us sit down to face the personal problem of how to use and make the most of our lives, and most of us lack an incentive powerful enough to override our inertia and compel us to effort," says Miss Gladwin.

The book should be a friendly guide in overcoming such inertia. It is not a treatise in ethics, it makes no pretense at comprehensiveness. It is a

series of friendly talks on a few of the more common problems which confront students and graduate nurses. The approach is forthright. In the chapter, "The Tone of a School," we find:

> Too much sentimentality surrounds the idea and practise of nursing. Helping mankind and serving those who suffer are noble ideals, but to be effective in nursing these ideals must animate and dictate rigid and vigorous preparation accompanied by hard work. Any pupil would find it to her advantage to ask herself whether she would have entered the nursing field if she had had plenty of money and not found it necessary to earn a living. An honest answer to that question does much to clear the atmosphere.

Summing up the chapter on "Ethics and Duty" she says, "Ethics is quite distinct from religion, but the noblest concept of the life governed by ethical principles is that which accepts St. Paul's beautiful description of charity beginning, 'Charity suffereth long and is kind.'"

The chapters "The Patient and the Nurse," "Gossip," "Truth," "Discipline," "Punctiliousness," "The Opposite Sex," "Good Manners," "Fees and Gifts" contain practical discussions of all-too-common problems. The chapters "Vocabularies and Books," "Success," and the lovely concluding chapter on "Our Exemplar" (Miss Nightingale) should have wide reading.

The book will be warmly welcomed by teachers of ethics. It might be made more convenient for such use by placing the thought-provoking questions, which are now interpolated in the text, at the end of the chapters. It has real value for graduate nurses and some of the chapters, such as "Fees and Gifts," and "Success," might profitably be used for alumnae programs.

M. M. R.

New York

PRACTICAL PLANNING FOR HOSPITAL FOOD SERVICE. The John Van Range Co., Cincinnati. 1930. Copy sent on request.

WHILE this exceedingly well illustrated pamphlet is frankly gotten up for advertising purposes, it contains much valuable information for those who are confronted with the problems of planning for hospital food service. The plans of many recently built hospitals are included to illustrate different types of food service. The advantages and disadvantages of the two methods of food service are considered—as are space requirement and the factors influencing it, such as the method of serving, the addition of new departments, problems of the special hospital, and the like. An analysis of food service space in twenty-three hospitals is presented in tabular form. There is also a table showing the architectural and engineering problems which must be considered in hospital food service planning. One section is concerned with equipment. Copies of the pamphlet may be had by writing to the John Van Range Co., Oakley, Cincinnati, Ohio.

H. W. M., R.N.

New York

Books Received

OUR WANTS AND HOW THEY ARE SATISFIED. By Mollie Ray Carroll. 72 pages. M. Barrows & Company, Boston. 1930. Price, $1.

A simple, readable statement of the basic principles that underlie our economic system.

GENERAL PSYCHOLOGY FOR COLLEGE STUDENTS. By Carl Newton Rexroad, Ph.D. 392 pages. Illustrated. The Macmillan Company, New York. 1929. Price, $2.10.

LECTURES ON COLONIC THERAPY. By O. Boto Schellberg. 55 pages. Illustrated. The Oboschell Corporation, New York. 1930. Price, $2.

Official Directory

International Council of Nurses.—Sec., Christiane Reimann, 14 Quai des Eaux Vives, Geneva, Switzerland.

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